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Public Health.

CITY AND COUNTY OF THE CITY OF EXETER



EDUCATION COMMITTEE

ANNUAL REPORT

UPON THE

SCHOOL HEALTH SERVICE

FOR THE

YEAR ENDED 31st DECEMBER, 1967

E. D. IRVINE, M.D., M.R.C.S., D.P.H.,
PRINCIPAL
SCHOOL MEDICAL OFFICER



HOUSES IN THE CATHEDRAL CLOSE

Number 1 (at the left of drawing) now known as Mol's Coffee House, was probably built in 1596; the Queen's Admirals used to meet here in the Armada Room.

Numbers 1 to 5 are all on part of the site of the Annuellars' College. The Annuellars took their name from the commemorative masses celebrated annually for the good of the souls of various benefactors.

Number 6 the Sub-Deanery; though the front is probably Georgian, the internal and rear masonry retain some mediaeval features.

Number 7, the lease was bought by the Devon and Exeter Institution in 1813. Two lofty halls with galleries were later erected, with domed lanterns in the roof; the Institution's library now houses over 40,000 volumes. The residence at the rear retains some sixteenth century and earlier features including a handsome carved oak overmantel with fluted pilasters and round arches, very similar to the work of 1593 in the Guildhall.

Number 8 has a fine mediaeval hall probably used as a Notorial Bureau or office for the examination, attestation, drawing up and copying of documents, perhaps a department of the Diocesan Chancery.

Number 9 was probably a gate-house, it is very quaint externally and internally, and has a street door with moulded wraps and iron studs, low heavy-beamed ceilings and irregular floors, several Tudor features and an elegant Adam mantelpiece.

The drawing is by Mr. Michael Mason, formerly of the College of Art, Exeter, and the details above have been kindly supplied by the City Librarian, Mr. N. S. E. Pugsley, F.L.A.



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SCHOOL HEALTH DEPARTMENT,
1A, SOUTHERNHAY WEST,
EXETER.

April, 1968.

To the Chairman and Members of the Education Committee.

Mr. Chairman, Ladies and Gentlemen,

HEALTH/
OBESITY

Our assessment of the health of the school children and the work of the School Health Department during 1967 are set out in this report. The general health of the children was very satisfactory, though it must be conceded that the absence of recorded unsatisfactory general condition, as stated by our very experienced doctors, does not tell the whole story, as evidenced by the attendance of a number of children at our newly-started obesity clinic. Obesity in itself is an unsatisfactory nutritional state, and the simple classification of general condition as satisfactory or unsatisfactory, is not easy to determine accurately. A factual and interesting report on the work of the obesity clinic, has been prepared by Dr. G. P. McLauchlan, and included as Appendix I.

MEDICAL
EXAMINATIONS

The system of medical examination—viz. the selective system—remained substantially unchanged. We experimented with examinations of the prospective school entrants in the term preceding admission. This has worked well in Newcastle-on-Tyne. We have not yet come to any firm conclusion as to its merits.

NEW
SCHOOLS

The school population increased by 393. Two new schools were opened—Redhills Junior Mixed and Infants (280 places) serving an area including considerable new housing development, and Southbrook Day Special School (140 places) for Educationally Subnormal Children from both Exeter and surrounding areas of the County. This school, the need for which has been pressing for several years, has well justified itself. It is very pleasantly sited. With the approval of the Director of Education, Mr. D. J. Thomas (educational psychologist) and the school doctors interviewed the parents of all those children they had jointly considered as suitable for entry to the school. This careful and sympathetic approach to the parents, which certainly made heavy demands on the staff, proved well worth while, and the parents have since expressed their appreciation of the work of the school for their children. Mr. D. S. Kerr (headmaster) has contributed a short note on the first year's experience.

INDEPENDENT
SCHOOLS

I am glad to be able to say that the governors of St. Margaret's School, one of the independent schools in the city, have with the support and encouragement of the

medical officer to the school (Dr. Hugh Powell) asked for the services of the School Health Department to be made available to the school, from September, 1967. A nominal annual charge of 5/- per child on the school roll is made. This is the only independent school which has made this arrangement and its progressive attitude is to be much commended. I would like to see this provision extended entirely free to all school children in the city whatever the schools they attend, and this is also the view of the British Medical Association's National Conference of Public Health Medical Officers. (B.M. Jl. 6/4/68.)

PARTIALLY
HEARING

The audiology service continued to progress. During the year Dr. A. M. Tucker (school medical officer) surveyed in detail the more severely partially deaf children in the schools, and in conjunction with the newly-appointed welfare officer for the deaf (Rev. W. B. Brown) who is on the staff of the City Welfare Department, investigated and discussed the help needed for each child on leaving school. Dr. Tucker's useful and interesting summary is included in these pages, as is also a stimulating and comprehensive report on her work by Miss M. M. Godsland (senior peripatetic teacher of the partially hearing). The audiology unit has proved of enormous value.

HANDICAPPED
CHILDREN

In accordance with the Department of Education & Science and Ministry of Health joint circular 9/66, further consideration was given to the co-ordination of effort by public and voluntary agencies on behalf of handicapped children. The conclusions are set out in Appendix II. Miss G. M. Bastow, health visitor, continued specialised visiting for handicapped children and I have included some notes by her on this theme.

SPEECH
THERAPY

Speech therapy has continued under great difficulties. Because of staff shortage there is a serious possibility of complete break-down in this service, which has continuously been effective and most useful over the last twenty years. It is far more important to speak well, that is without defect such as lisping, stammering, etc., than to write well. Miss Hastings has discussed some of her work on speech education in children with cleft palate, and this makes interesting reading. The Committee have agreed to convert a small war-time store adjoining our audiology unit into a speech therapy centre; this will be a great advance, and may be the means of attracting speech therapists to the school health service.

DENTAL
SERVICE

The dental service has continued fully staffed; the five clinics are all modern and well equipped. Fluoridation has not been discussed here recently. Clearly it should be the subject of Parliamentary direction.

CHILD
GUIDANCE

The Child Guidance staff has been strengthened; a part-time psychiatric social worker (4 sessions a week) and

a part-time educational psychologist (3 sessions a week) were appointed during the year. Dr. C. J. Wardle, Consultant in the Child Guidance Clinic, is also in charge of the children's psychiatric unit in Wonford Hospital; though this latter is not a responsibility of the Education Committee, its work is complementary in some sense to that of the Child Guidance Clinic.

HEALTH EDUCATION

Health Education continues in the schools and Miss E. H. Robertson (health education organiser) has had considerable help from the girls' secondary school head teachers to which she refers in her note on the subject.

STAFF

Dr. A. M. Tucker resigned to take up general practice in Jersey; he had done good work during his short stay here. Dr. M. Allen was appointed as school medical officer and assistant medical officer of health to commence duty on January 1st, 1968. The frequent changes in medical and other professional staff has been a great handicap in recent years. Miss C. M. Wilkinson (superintendent health visitor/school nurse) resigned in the Spring, to enter a religious order and was succeeded by Miss A. J. Hemingway. Miss Wilkinson had been zealous on behalf of the children and her sincerity was evident in all she did. The department sends its good wishes to Dr. R. P. Boyd and Miss P. P. Horne, health visitor. Dr. Boyd (chest physician) (formerly up to 1948 Deputy Medical Officer of Health to the city) has been ill for some months; he has always helped the department most willingly in relation both to infectious diseases and tuberculosis in children. Miss Horne, too, who has done good work as a health visitor and school nurse for several years, has suffered illness for many months.

ACKNOWLEDG- MENTS

It only remains to thank all who have helped the work of the department during the year, in particular the Chairman of the Education Committee (Alderman W. G. Daw) and the Chairman of the Special Services Committee (Alderman Mrs. M. Nichols, B.Sc.) and all the Committee, the Director of Education (Mr. J. L. Howard, M.Sc.) and the heads of schools and teaching staffs, without whose willing help nothing useful could be done; also the doctors in the city, the press, and above all the parents, who are almost invariably completely co-operative in all that applies to the welfare of the children. All my staff have taken great interest in the work; Mr. W. H. Stamp, administrative assistant, has as always been of the greatest help to me and to the schools in all the arrangements necessary for the work of the department.

Yours truly,

E. D. IRVINE,

Principal School Medical Officer.

EXETER EDUCATION COMMITTEE
(as constituted on 31st December, 1967)

The R.W. The Mayor
(Alderman R. E. C. BOARD, J.P.)

Alderman W. G. DAW
(*Chairman*)

(Alderman W. J. HALLETT, T.D., LL.B.)
(*Deputy Chairman*)

Committee

Alderman W. Hunt	Councillor D. J. Morrish, M.SC., F.R.G.S.
Alderman Mrs. M. Nichols, B.SC.	Councillor P. E. Parish
Alderman R. W. Pyne	Councillor H. S. Sargent
Alderman P. A. Spoerer	Councillor R. Sim
Councillor P. E. Aylward	Councillor A. Speller, B.SC., B.A.
Councillor M. J. H. Cooke	Councillor F. K. Taylor
Councillor G. A. Joy	Councillor Mrs. I. West
Councillor S. F. Liddicoat	Councillor V. D. Whitburn, L.L.C.M.
Councillor N. W. F. Long	
Councillor A. V. Macan	Councillor Mrs. R. Wickings

Co-opted Members

Mr. R. H. T. Burgess, F.C.A.	Mr. S. I. Medlar, M.A.
Miss M. N. Church, B.SC.	Prof. W. E. Minchinton.
Mr. D. J. Holding, M.A.	Rev. Canon T. Pritchard, M.A.
Mr. S. T. Knowles, B.A.	Mr. J. Turner, B.SC.
Miss S. Y. Mathias, M.A.	Mrs. W. Unthank, B.SC.

J. L. HOWARD, M.SC., A.R.I.C., *Director of Education*

E. D. IRVINE, M.D., M.R.C.S., D.P.H., *Principal School Medical Officer*

STAFF OF THE SCHOOL HEALTH DEPARTMENT

Principal Sch. Med. Officer & Medical Officer of Health	EDWARD D. IRVINE, M.D. (LIV.), M.R.C.S., L.R.C.P., D.P.H.
Dep. Principal Sch. Medical Officer & Dep. Med. Officer of Health.	GEORGE P. McLAUCHLAN, M.B., CH.B., (EDIN.), D.P.H., D.C.H.
School Medical Officers and Assistant Medical Officers of Health.	IRIS V. I. WARD, M.D. (LOND.), M.R.C.S., L.R.C.P., D.C.H. ELIZABETH L. RYAN, M.B., B.CH., L.M., D.P.H. (DUBLIN). ALAN M. TUCKER, M.B., B.S., D.OBST. R.C.O.G., D.P.H. (BRIS.) (Resigned 31.10.67). BARBARA C. SEMPLE, M.B., CH.B. (LIV.).
Principal Dental Officer	ALVIN PRYOR, L.D.S., R.C.S. (ENG.).
Dental Officers	ROBERT B. MYCOCK, L.D.S. (BRIS.). TALBOT N. PRAAT, L.D.S., R.C.S. (ENG.). GILLIAN A. RAMPTON, L.D.S. (DURHAM).
Child Guidance Centre :	
Medical Director	HARDY S. GAUSSEN, M.R.C.S., L.R.C.P. (Part- time).
Consultant Psychiatrist....	*CHRISTOPHER J. WARDLE, M.D., D.P.M. (Part- time).
Educational Psychologists	DAVID J. THOMAS, B.A. (HONS.), DIP. ED. PSYCH. MRS. M. F. WHINNOM, B.SC. (SPEC. HONS.) (Appointed 1.9.67 (Part-time).
Psychiatric Social Workers	MRS. M. C. JENKIN, B.A. (HONS.), A.A.P.S.W. MRS. M. BRANCH, B.SC. (HONS. ECON.), A.A.P.S.W. (Appointed 3.7.67) (Part-time).
Speech Therapists	MISS I. W. HASTINGS, L.C.S.T. MRS. M. PEEL, L.C.S.T. (Part-time). MRS. I. J. COPE, L.C.S.T. (Part-time) (Resigned 8.2.67). MRS. M. A. REES, L.C.S.T. (Part-time).
Superintendent School Nurse (Also Supt. Health Visitor)	†MISS C. M. WILKINSON (Resigned 30.4.67). †MISS A. J. HEMINGWAY, Cert. Comm. Health Admin., Dip. in Sociology (Appointed 2.10.67).
School Nurses (Also Health Visitors)	‡MISS D. ALLOWAY, Q.I.D.N. (Appointed 2.1.67) (Resigned 5.8.67). ‡MISS L. M. BARRETT ‡MISS G. M. BASTOW ‡MISS G. A. BOND ‡MISS B. A. BRAZIL (Retired 30.6.67) (Part- time from 23.10.67). ‡MISS Y. CASELLI, R.F.N. ‡MISS H. C. K. CHAPMAN ‡MISS M. J. COOK ‡MRS. K. DUNHAM ‡MISS H. C. FRASER (Appointed 21.8.67). ‡MISS P. P. HORNE

* Regional Hospital Board appointment.

† S.R.N., S.C.M., H.V. Cert.

‡ S.R.N., S.C.M. (Part 1), H.V. Cert.

School Nurses (Also Health Visitors) (cont.)	†Miss C. S. NEWTON, Q.N.
	†Miss A. E. RADCLIFFE (Appointed 1.8.67).
	‡Miss H. M. SHEWAN
	†Mrs. E. VEALE
	†Miss L. E. WATHEN
	†Miss J. WALLIS, B.T.A. Cert., Q.I.D.N. (Appointed 13.2.67).
School Nurses (Temporary) (Part-time)	Mrs. K. A. ATKINS, S.R.N.
	Mrs. D. M. WAKELY, S.R.N.
Clinic Nurses (Temporary)	Mrs. V. M. M. BRICE, S.R.N.
	Mrs. T. S. TILLER, S.R.N.
Audiometricians (Part-time)	Mrs. M. B. CHUBB, S.E.N.
	Mrs. P. E. D. ROBERTS, S.R.N.
Dental Attendants....	Miss P. M. BOLT
	Mrs. Y. EASTLICK
	Miss D. G. FREEMAN
	Miss M. J. LANGWORTHY (Resigned 5.11.67).
	Miss J. I. FULL (Appointed 27.11.67).
Administrative Assistant	Mr. W. H. STAMP
Clerks	Mrs. C. J. SLACK (Resigned 11.8.67).
	Mrs. L. M. HALEY (formerly Miss L. M. Bond)
	Mrs. L. LEE
	Miss J. A. LARCOMBE
	Miss S. A. WEBBER
	Miss P. GATRELL (Appointed 16.10.67).
	Mrs. J. M. CANN (School Dental Service).
	Miss M. A. FENWICK (Child Guidance Clinic).
	Mrs. G. WYKES (Child Guidance Clinic) (Part-time).

† S.R.N., S.C.M., H.V. Cert.

‡ S.R.N., S.C.M. (Part 1), H.V. Cert.

STATISTICS AND GENERAL INFORMATION

Population of City (Mid-Year 1967)	....	....	92,550
Population (city) over 5 and under 15 years (Mid-Year 1967)	12,400		
(Registrar-General's estimate).			
Population of Maintained Schools in January 1968	....		12,841
Number of Maintained Schools	....	....	42

PUPILS			SCHOOLS	
Boys	Girls	Total	Department	Number
27	18	45	Nursery	1
1,609	1,491	3,100	Infants	21
2,454	2,253	4,707	Junior	22
1,689	1,567	3,256	Secondary Modern	7
859	730	1,589	Secondary Grammar....	2
4	2	6	Hospital Special School	1
73	65	138	Day Special School	1
6,715	6,126	12,841	TOTAL	55

Those schools having both infants and juniors have been counted as having two departments.

The number of children on roll shows an increase of 393 compared with January, 1967.

Two new schools were opened during 1967, viz. : Redhills Junior Mixed and Infants opened in September, 1967, for 280 children and for 480 ultimately, and Southbrook Day Special School opened in April 1967, for 140 educationally sub-normal boys and girls between 7 and 16 years of age.

SCHOOL PREMISES

The following abstract (by courtesy of the City Architect, Mr. Vinton Hall, A.R.I.B.A., A.M.T.P.I.) shows details of work carried out by his department which directly affects the environmental and hygiene conditions in the schools. It does not, of course, list all the work undertaken by the City Architect for the Education Committee.

(a) School Meals Service

As part of a phased programme of replacing glazed stoneware washing-up sinks, wooden draining boards, and galvanised iron sterilizing sinks, 9 schools were provided with replacement sterilizing sinks, and 1 with new vegetable sink units.

Wash-hand basins with hot water were fitted in the kitchens at Summerway Primary School, Priory Secondary Modern Girls' School and also in the accommodation used by school meals staff at 17, St. David's Hill.

Internal redecoration was carried out to accommodation used for school meals in 9 schools. Other minor work was also carried out.

(b) Alterations

The lavatory accommodation at Bradley Rowe Schools was improved by roofing over the open portions, and by the addition of wash-hand basins.

In the Pavilion at Exhibition Fields, which is used for teaching purposes in connection with the Beacon Heath J.M. & I. School, the floors of the two classrooms were covered with Vinyl tiles. The cost of the work was shared between the Education Committee and the Devon County Agricultural Association.

An indoor swimming pool was opened at St. Hilda's Hall, York Road, for teaching children to swim. The water in the pool and the Hall itself is heated by a new oil-fired heating installation which heats the water used in the school meals kitchen adjoining, and also the Bishop Blackall School dining accommodation.

A building originally erected by the Ministry of Works at the Cowick Barton Playing Fields to provide domestic science accommodation for St. Thomas Secondary Modern School, being no longer required for this purpose, was adapted to provide changing accommodation and showers for use by John Stocker Schools.

The electrical installation at the Bradley Rowe Schools was further re-wired and modernised. Bradley Rowe Junior Boys' School was dealt with during the year under review (Phase III). Electric off-peak storage heating has been provided in Topsham Infants' and St. Thomas Junior Mixed and Infants' Schools.

The heating installation at Countess Wear Infants' School was converted from solid fuel to oil firing.

Further portions of the electrical installation at Newtown School were re-wired in the interests of safety.

Floors in part of 3 schools were renewed.

(c) Internal Decorations

Internal decorations of a major character were carried out in schools and colleges : Beacon Heath Junior Mixed and Infants', Bradley Rowe Infants', Bradley Rowe Junior Boys', Bradley Rowe Junior Girls', Countess Wear Junior Mixed, St. Thomas Junior Mixed and Infants', Topsham Infants', Topsham Junior Mixed, Whipton Barton Junior Mixed, Whipton Infants', John Stocker Secondary Modern Boys', Ladysmith Secondary Modern

Boys', The Priory Secondary Modern Girls', St. James Secondary Modern Girls', Vincent Thompson Secondary Modern Boys', Hele's School, Bishop Blackall School, The College of Art, The Technical College, The Community Centre (17, St. David's Hill).

(d) Minor Redecoration

In addition to the internal redecoration work referred to above, minor work was carried out at twelve other schools or properties controlled by the Education Committee.

SCHOOL HYGIENE

The medical officers, with the head teachers, make regular inspections of schools to see that the sanitary accommodation, ventilation, lighting and heating, washing facilities, cleanliness, school furniture and canteen arrangements are suitably maintained. The following significant findings have been referred to the Director of Education and he has told me that they will be dealt with or are included in the work to be carried out as soon as is practicable.

Chestnut Avenue Nursery School—serious overcrowding during rest periods, insufficient arrangements for dealing with soiled clothing, unsatisfactory storage of milk and the absence of a separate washbasin for the kitchen staff.

Central School—unsatisfactory lavatory accommodation which will be rectified when the modernisation of this school is carried out.

Ladysmith Junior Mixed School—insufficient washbasins in the lavatories and worn surface glaze in the boys' urinal.

Pinhoe Infants' School—unsatisfactory school furniture, overcrowding at school dinners, and offensive odours from boys' urinal.

Pinhoe Junior School—overcrowding in classrooms, inadequate lavatory and playground accommodation.

St. Nicholas School—lack of drying facilities for the children's clothes.

St. Thomas Girls' Secondary Modern School—insufficient cloakroom accommodation.

Stoke Hill Junior School—insufficient cloakroom accommodation, repairs needed to male staff urinal; storage of milk inadequate.

Stoke Hill Infants' School—return springs recommended to prevent doors slamming; the provision of paved area outside the french windows recommended.

Summerway Junior School—soundproofing of medical room.

Topsham Infants' School—unsatisfactory stoves for heating and very rough and dust-retaining walls in the classrooms.

Topsham Junior School—more variation in the size of the desks recommended and improvement to the girls' playground.

Whipton Infants' School—the provision of a cloakroom and lavatory facilities adjoining the canteen.

Countess Wear Schools—complaints were received about the nuisance from smells from the nearby city sewage works, which at the moment is not preventable, despite much effort to alleviate it. The smell is very objectionable and I sympathize with the teachers, children and all the inhabitants of the area. The City Council's programme of improvement to the sewage works is massive, costing well over one million pounds, and should eliminate this annoyance when completed within the next two years.

MEDICAL EXAMINATIONS

The general system was unchanged but the "leaver" examination in the girls was transferred from age 13 to age 14. As a result most of the girls in this age bracket (14 years) had been examined at age 13 in 1966, and were of course not re-examined, having reached 14 years. In 1968 the group reaching 14 years of age will all be examined.

In a total maintained school population of 12,841 the periodic medical examinations numbered 1,848 (i.e. 1,348 entrants and 500 13 year olds) and "other medical examinations" 5,274. In no child was the general physical condition considered "unsatisfactory". Parents were present at 1,622 (88%) of the "periodic" examinations (see table below). They are usually invited to be present at re-examinations and special examinations, but their attendances at these are not recorded. 257 children (i.e. approx. 1 in 7 of those examined at the periodic examination) were found to require treatment for some defect other than dental disease or verminous conditions.

Ear, Nose and Throat Conditions

Discharging ear was noted in 12 children (4 boys ; 8 girls)—all entrants—out of the children examined at periodic medical examinations ; in addition 1 was found in 1,212 special examinations and 10 more in 4,062 re-examinations. 17 of these children were already having treatment and the other 6 were referred for investigation and/or treatment.

20 children (11 from periodic and 9 from special examinations) were referred for treatment of other nose and throat "defects", whilst a further 190 children were kept under observation for similar reasons.

General Condition of the Children

The general physical condition of the children continues to be satisfactory ; no child was classified as being unsatisfactory, although some children were overweight (see Appendix I). Really, obesity cannot be counted as satisfactory.

**PARENTS' ATTENDANCES AT COMPLETE
PERIODIC EXAMINATIONS**

AGE GROUP	No. of children examined	No. of parents present	Percentage	
			1967	1966
5 year olds	1,348	1,330	99%	97%
13 year olds	500	292	58%	69%
TOTAL	1,848	1,622	88%	86%

MEDICAL EXAMINATIONS 1967

Statistics

Total Number of Children Examined

Year :	1962	1963	1964	1965	1966	1967
Special Examinations	1,237	746	983	882	1,232	1,212
Re-Examinations	2,196	2,586	3,441	3,344	3,843	4,062
	<u>3,433</u>	<u>3,332</u>	<u>4,424</u>	<u>4,226</u>	<u>5,075</u>	<u>5,274</u>
Periodic Medical Examinations....	1,904	1,701	1,998	1,728	1,823	1,848
TOTAL	<u>5,337</u>	<u>5,036</u>	<u>6,422</u>	<u>5,954</u>	<u>6,898</u>	<u>7,122</u>

A re-examination is an inspection arising out of one of the periodic medical inspections or out of a special inspection. A special examination is one that is carried out at the special request of a parent, doctor, nurse, teacher or other person ; and include also employment examinations and "inward transfers".

Number of Children Referred to Hospital

	1959	1961	1962	1963	1964	1965	1966	1967
Ear, Nose and Throat cases	29	76	112	96	86	56	51	30
Other cases	73	62	52	53	73	87	51	39
TOTAL	<u>102</u>	<u>138</u>	<u>164</u>	<u>149</u>	<u>159</u>	<u>143</u>	<u>102</u>	<u>69</u>

Of the 39 "other cases" referred in 1967 to hospital consultants, 25 were for orthopaedic and 14 for other conditions.

Special Selective Examinations

- (a) Complete medical examination 817—many of these were of children recently transferred into the City.
- (b) Medical examination—not complete, i.e. not involving all systems 265.

(a) Special (Complete) Examinations

Out of the 817 children examined, 339 were found to have defects requiring treatment or observation. All the children were seen at the request of the medical officers, none being referred by teachers or parents.

DEFECTS FOUND.

REFERENCE FOR TREATMENT OF DEFECTS OF :

Skin	5	Orthopaedic, posture	4
Vision	53	Orthopaedic, feet	10
Squint	5	Orthopaedic, other	9
Eyes, other	1	Nervous system—	
Hearing	3	Epilepsy	4
Otitis	2	Other	1
Ears, other	8	Psychological development	1
Nose and Throat	5	Psychological stability	2
Lungs	7	Abdomen	3
Developmental—		Other	2
Hernia	1		
Other	3		
Speech	7		
		TOTAL	136

KEPT UNDER OBSERVATION FOR DEFECTS OF :

Skin	7	Orthopaedic, posture	11
Vision	54	Orthopaedic, feet	12
Squint	1	Orthopaedic, other	9
Hearing	28	Epilepsy	2
Otitis	6	Nervous system, other	2
Ears, other	7	Psychological development	6
Nose or throat	16	Psychological stability	9
Speech	2	Abdomen	4
Lymphatic glands	1	Other	8
Heart and circulation	3		
Lungs	11		
Developmental—			
Hernia	2		
Other	2		
		TOTAL	203

(b) **Special Examinations**, i.e.—not complete—involving, for example, cardio-vascular system, or respiratory system, etc.

265 children were medically examined in school by special request of school doctors (113), of head teachers (84), and of parents (68) ; of these, 81 required treatment and 93 were referred for observation ; 91 required no action.

The tables below set out the findings.

DEFECTS FOUND.

REFERRED FOR TREATMENT FOR DEFECT OF :

Skin	3	Orthopaedic, feet	2
Vision	20	Epilepsy	2
Squint	1	Epilepsy, other	1
Hearing	14	Psychological development	2
Otitis....	1	Psychological stability	4
Nose or throat	4	Abdomen	1
Speech	6	Other	15
Heart and circulation	2		
Lungs	3	TOTAL	81

KEPT UNDER OBSERVATION FOR DEFECTS OF :

Skin	3	Orthopaedic, other	2
Vision	10	Nervous system, other	4
Hearing	4	Psychological development	7
Nose or throat	13	Psychological stability	2
Speech	6	Abdomen	2
Heart or circulation	3	Bladder control	6
Lungs	4	General condition	16
Developmental, other	1	Other	6
Orthopaedic, posture	2		
Orthopaedic, feet	2	TOTAL	93

MEDICAL QUESTIONNAIRES

The use of medical questionnaires and subsequent selection of those to be examined in place of the " 13 year-old periodic medical examination " was continued at Hele's (boys' grammar) School. As previously stated, because of the change in the arrangements about the older girls, no questionnaires were used for Bishop Blackall (girls' grammar) School this year.

There were 119 boys at Hele's School in this 13-year old group ; as previously, the medical questionnaires were distributed to the parents through the co-operation of the headmaster and his staff ; 118 were returned.

They showed in 39 instances some medical condition causing anxiety to the parent. In 18 the boys were already under observation by the school doctor ; of the 21 other, 4 had recently moved into the city area and 1 left the city before he could be examined.

RESULT OF EXAMINATION

Suspected defect as reported by Parent	Total	Referred for Treatment	Requiring Observation	Considered Normal
Heart	2	—	1	1
Skin	1	—	1	—
Colour Vision	2	—	—	2
Lungs	7	—	2	5
Nose and Throat....	6	1	2	3
Hearing	6	3	1	2
Epilepsy	1	1	—	—
Migraine	2	—	2	—
Weight	3	1	2	—
Orthopaedic	1	—	1	—
Neurosis	1	—	1	—
Vision	5	3	2	—
Abdomen	1	1	—	—
	38	10	15	13

INDEPENDENT SCHOOLS

79 children were examined at St. Margaret's School. 19 individual children showed some condition requiring treatment. Screening tests of hearing will be offered early in 1968 ; routine vision testing will also be affected. All children in the city have access to certain special facilities not readily available otherwise, e.g. speech therapy, child guidance, the priorities being determined strictly on the degree of medical need.

HEIGHTS AND WEIGHTS

(Periodic Medical Examinations)

BOYS' HEIGHTS

LONDON SCHOOL CHILDREN (1959)*		EXETER BOYS						
Age	Height in inches	Age	No. Exam- ined in 1967	Average Height in Inches				
				1967	1966	1965	1964	1963
—	—	4 (4-5) years	20	40.1	38.7	37.5	38.0	38.4
5½ yts.	43.75	5 (5-6) "	285	42.7	43.3	43.3	43.3	42.9
6½ "	46.25	6 (6-7) "	373	43.8	43.6	43.9	43.5	44.1
12½ "	59.0	12 (12-13) "	224	61.9	61.3	60.5	60.6	60.4
13½ "	61.25	13 (13-14) "	74	62.2	62.5	61.6	62.0	62.5
14½ "	64.25	14 (14-15) "	5	63.5	62.9	66.2	64.4	63.4

BOYS' WEIGHTS

LONDON SCHOOL CHILDREN (1959)*		EXETER BOYS						
Age	Weight in pounds	Age	No. Exam- ined in 1967	Average Weight in Pounds				
				1967	1966	1965	1964	1963
—	—	4 (4-5) years	20	39.1	36.7	34.3	34.2	36.4
5½ yrs.	44.0	5 (5-6) "	290	42.6	43.4	43.2	43.6	42.7
6½ "	49.0	6 (6-7) "	373	43.5	43.9	44.2	43.8	44.3
12½ "	92.0	12 (12-13) "	224	104.2	101.1	99.9	100.2	96.6
13½ "	103.5	13 (13-14) "	74	107.3	106.5	103.1	107.0	110.2
14½ "	116.75	14 (14-15) "	5	119.2	112.8	123.1	117.9	110.7

GIRLS' HEIGHTS

LONDON SCHOOL CHILDREN (1959)*		EXETER GIRLS						
Age	Height in inches	Age	No. Exam- ined in 1967	Average Height in Inches				
				1967	1966	1965	1964	1963
—	—	4 (4·5) years	26	39·5	38·4	40·1	37·4	39·2
5½ yrs.	43·5	5 (5·6) "	281	42·8	42·8	43·0	43·1	42·7
6½ "	46·0	6 (6·7) "	337	43·5	43·4	43·4	42·7	42·7
12½ "	59·75	12 (12·13) "	25	61·6	61·2	61·6	61·0	61·2
13½ "	61·5	13 (13·14) "	113	62·4	62·4	61·1	62·2	61·8
14½ "	62·75	14 (14·15) "	45	63·1	62·2	62·4	62·5	62·2

GIRLS' WEIGHTS

LONDON SCHOOL CHILDREN (1959)*		EXETER GIRLS						
Age	Weight in pounds	Age	No. Exam- ined in 1967	Average Weight in Pounds				
				1967	1966	1965	1964	1963
—	—	4 (4-5) years	26	35.4	34.8	38.2	33.8	38.4
5½ yrs.	42.75	5 (5-6) "	288	42.0	42.3	42.2	43.2	41.6
6½ "	48.5	6 (6-7) "	337	43.5	43.0	43.4	43.0	41.3
12½ "	96.75	12 (12-13) "	25	101.0	107.8	107.8	105.3	107.5
13½ "	108.0	13 (13-14) "	113	115.5	113.8	110.4	112.6	111.6
14½ "	114.75	14 (14-15) "	45	118.2	114.4	113.6	112.8	113.9

Procedure re Heights and Weights**Heights :** All children are measured in their stockinged feet.**Weights :** **Boys**—wearing shirt, underclothes, trousers and socks.**Girls**—wearing dress or blouse and skirt, underclothes and socks or stockings.

* Report on the Heights and Weights of School Pupils in the County of London in 1959 (L.C.C., 1961). (normal underclothing, without shorts and jacket, etc.).

NOCTURNAL ENURESIS (Bed Wetting)

New Cases (113, all ages)

During the year 94 "new cases" of nocturnal enuresis (55 boys—39 girls) were noted by school doctors among 1,348 children examined at the periodic medical examination at school entry, once again a higher proportion than in the previous year. Additionally 11 new cases (6 boys—5 girls) were found among 4,062 of various ages re-examined and 8 (6 boys—2 girls) among 1,212 of various ages having special examinations—a slightly lower proportion than in 1966.

NEW CASES

Frequency of Bedwetting	Every night	Two or Three times a week	Once a week	Occa- sional	Total
Girls 	32	3	2	9	46
Boys 	42	9	2	14	67

NEW CASES — FAMILY SIZE

Size of Family	No. of Families	Sex of children concerned	
		Girls	Boys
Only child 	11	5	6
One of two children 	28	12	16
One of three children 	34	12	22
One of four children 	19	7	12
One of five or more children 	21	10	11
TOTAL 	113	46	67

Family History

In 24 children (10 girls—14 boys) there was a history of bed-wetting in near relatives.

Intelligence

Only one child had an intelligence test—boy, I.Q. 55.

Maladjusted

Seven of the children (3 girls—4 boys) were attending the Child Guidance Clinic.

Speech Defect

Five children (4 boys—1 girl) were having treatment from speech therapist for speech defect.

Other Defects

Four children (2 boys—2 girls) had vision defects ; 5 children (3 boys—2 girls) had defective hearing ; 2 (girls) were “ highly strung ” ; 1 (girl) suffered from slight hernia ; 1 (boy) was having hospital treatment for purpura ; 1 (boy) suffered from epilepsy ; 3 had other defects.

Specific Alleged Causes

Enuresis started :—on entry to school 4 (3 girls—1 boy) ; after entry to junior school 1 (boy) ; after the birth of younger siblings 2 (boys) ; on entering Princess Elizabeth Orthopaedic Hospital for deformity of knees 1 (girl) ; after operation for circumcision 1 (boy) ; after hernia operation 2 (boys) ; after treatment for Perthes' disease 1 (boy) ; after mother started to foster another child 1 (boy). Among other alleged causes were :—1 (boy) was very nervous, another boy was afraid of the dark and was referred to Child Guidance Clinic ; 1 girl had urinary tract infection and 1 girl slept with her sister who was enuretic.

Treatment with the Electric Alarms during 1967

This was under the supervision of Dr. Tucker.

Cases were chosen on the same general lines as previously described. Home visits by school nurses were made at 1 month and 6 months after the return of the apparatus to ascertain the immediate results of treatment, which are set out below.

Thirty-seven children (10 girls—27 boys) were loaned an alarm during the year ; 7 were at the request of the family doctors and 3 at the request of the Child Guidance Clinic ; 11 children were still using the alarm at the year end. The results of the 26 children who had completed treatment were as follows :—

RESULT AT THE END OF THE YEAR

Period Elapsed after return of alarm	DRY		OCCASIONALLY WET		No IMPROVE- MENT	
	after 1st course	after 1st relapse	after 1st course	after 1st relapse	after 1st course	after 1st relapse
Immediate condition on return of alarm	—	—	—	1	5	2
After 1 month	6	—	2	2	—	—
After 6 months	3	—	1	1	—	3
TOTAL	9	—	3	4	5	5
	9 dry		7 occ. wet		10 no improvement	

The reason for failure was not apparent in 2 cases ; the alarms were not used properly in 2 ; 2 children were heavy sleepers ; 2 children suffered from emotional tension ; 1 girl was having treatment for congenital bladder defect and 1 child was referred to own doctor for ? referral to hospital.

It was not possible to treat a number of enuretic children from large families, because frequently they were found to occupy the same room as other children and it was considered that neither the individual child nor the rest of the family would benefit from attempting treatment with an alarm. A number of mothers declined the use of the alarm on the grounds that it would wake their neighbours, as well as their own children, and this is worth bearing in mind when considering instituting alarm therapy. No " buzzer skin ulcers " have been noticed in Exeter during 1967 and it seems likely that the transistorised alarm will now supersede other types.

PARTIALLY HEARING CHILDREN

The statistical details about partially hearing Exeter children are set out below.

(a) School Children

	At year end	1967	1966
School Population		12,841	12,488
1. Attending Schools for the Deaf			
(a) Royal School for the Deaf, Exeter		22	23
(b) Summerfield House School for the Deaf, Worcestershire		1	1
(c) Mary Hare Grammar School for the Deaf, Berkshire		1	1
2. Wearing Hearing-Aids and attending ordinary Schools including in brackets newly discovered, and provided with hearing-aids		37* (4)	48 (8)
* Includes 1 child attending a partially hearing unit attached to an ordinary school in Torquay.			

Children wearing hearing aids :

	INFANTS	JUNIORS	SECONDARY	TOTAL
Boys	1	8	6	15
Girls	2	8	12	22
TOTAL	3	16	18	37

3. Wearing Hearing-Aids and attending residential special schools because of handicaps other than deafness	2	2
4. Number of school children under observation at year end with some degree of hearing loss	692	488

The 692 remaining under observation :

	INFANTS	JUNIORS	SECONDARY	TOTAL
Boys	120	162	96	378
Girls	102	147	65	314
TOTAL	222	309	161	692

23 of these 692 children were referred to the ear, nose and throat consultants at the Royal Devon & Exeter Hospital, who advised :—tonsil/adenoid operations 15 ; for hearing aid 1 ; for further examination 4 ; not yet seen 2 ; left Exeter 1.

SWEEP TESTS

No. of 5 year olds given sweep test	1,217	1,073
No. of these children who " failed " sweep test	167	167
Further findings and action taken <i>re</i> the 167 children who failed sweep test :		
Hearing within normal limits after full test	48	84
Referred to Ear, Nose and Throat Surgeons (all were recommended for removal of tonsils/adenoids)	3	2
Absent for full audiometric test	3	6
Left Exeter	8	3
Remaining under observation	105	72

685 children whose parents had moved into Exeter during 1967 were given sweep tests :

52 were found to be defective and are to be kept under observation.

CHILDREN HAVING FULL PURE TONE AUDIOMETRIC TESTS

	1967	1966
(a) Having " failed " in sweep test (5 year olds)	167	158
(b) Wearing hearing aids	37	48
(c) Referred for other reasons (re-tests, etc.)	899	797
TOTAL	1,103	1,003
(306 or 28% of the 1,103 children were found to be within normal limits of hearing).		
(d) Children referred but failed to attend or left Exeter (1 died)	24	13
(e) Total number of tests and re-tests	2,469	1,817

AUDIOLOGY

(Report by Dr. A. M. Tucker)

In October, 1966 the Audiology Unit was opened. Since then the service available has extended considerably and the Unit is being increasingly used for the observation and differential diagnosis of children with communication disorders, many of which are not primarily caused by hearing defects. As in 1966 the Combined Assessment Clinic team continued to meet regularly to establish the diagnosis of difficult problems and discuss amongst themselves and with the parents the educational placement of the child. The team is supplemented on occasions by a consultant child psychiatrist, speech therapist and the child's general practitioner. The two-way observation window and the intricate

intercommunicating electrical installations are proving valuable. A large number of visitors have viewed the Unit since its inception and these included members of the Royal Society of Health, doctors attending the Exeter Postgraduate Medical Institute and paediatric courses, and a number of local family doctors, teachers and nurses.

Ascertainment

(1) Pre-School Children

The modified "at risk" register continued to be used as a source for free-field testing of babies of 8 months of age and this list was supplemented by various sources of referral. All "failures" were examined and assessed at pre-school audiology clinics by Dr. A. M. Tucker, Miss G. M. Bastow, Mrs. E. Veale (health visitors), and Miss M. M. Godsland, senior peripatetic teacher of the deaf, and from these clinics a number of children were referred for further assessment by the combined team. The diagnosis of profound deafness in one severely subnormal child, who was manifesting psychotic features and was attending the Junior Training Centre, was established only after electroencephalo-audiographic studies. Mr. R. E. Olding (headmaster) has kindly admitted to the nursery section of the Royal School for the Deaf some children with a communication disorder, where day-to-day observation has been considered advisable to assist diagnosis. His staff, particularly Mrs. Pollock, have contributed much valuable information in this way; one child, who was hitherto exhibiting many autistic features, has obtained sufficient therapeutic benefit from attendance in the nursery to enable her to return to an ordinary day nursery and to re-establish a more normal relationship with her own family.

(2) School Children

Mrs. M. B. Chubb and Mrs. P. E. D. Roberts, audiometricians, continued their "sweep-testing" of all 5 year olds and "inward transfers" and carried out full audiometric testing on all "failures" and on other children referred from many sources. Children with abnormal pure-tone audiograms have had supplementary tests of speech comprehension, as and when necessary, based on the use of phonetically balanced lists of words spoken at varying measurable intensities at 10 feet distance; then tests are carried out with child in two different positions, viz. : facing and not-facing the tester.

The addition to the staff of Miss M. M. Godsland from the Royal School for the Deaf as senior peripatetic teacher of the deaf, has had a marked beneficial effect on the guidance of parents, pre-school and partially hearing school children. Together with Mr. D. Robinson (teacher) she has maintained a close and vital link with the teaching staff of the schools and discovered and referred for diagnosis and treatment many children with hearing difficulties.

Unfortunately, despite meticulous revision and pruning of hospital waiting lists and despite large operating lists and the priority given to really urgent cases, some children are, between the time of consultation and obtaining the benefit of adenoidectomy and/or other relevant surgical procedures, missing hearing for speech to a degree sufficient to necessitate the provision of temporary hearing aids. Mr. P. G. Scott and Mr. T. L. Bradbeer, consultant ear, nose and throat surgeons, have continued to be most helpful and sympathetic, exercising their discretion to each child's benefit despite heavy pressure of commitments.

When the new Unit for Partially Hearing children opens in September, 1968 at the Royal School for the Deaf, it is anticipated that a number of partially hearing children now attending ordinary schools may benefit from the facilities available there by attending what might be styled "booster" teaching periods. This may well modify our thinking about the desirability of establishing partially hearing units in ordinary schools which are difficult to staff continuously and in some circumstances scarcely viable.

Pilot Scheme to Investigate the Value of Sweep-Testing Children at 9 years old

During two years (1962 and 1963) 770 children aged five to ten years attending three schools (2 infants and 1 infant and junior mixed school) had audiometric sweep tests using frequencies of 250, 500, 1,000, 1,500, 2,000, 3,000, 4,000, 5,000, 6,000 and 8,000 cycles per second. Of these 770 children—112 (14.5%) failed the test, i.e. showed defective hearing.

During 1967 it was decided to do a further sweep test on what was considered a representative sample of the group tested in 1962/1963 (now mostly nine year olds); 193 children at four of our junior schools were given the test, using the same frequencies as in 1962/63.

At the earlier test in (1962/63) 41 of these 193 children had failed (21%); in 1967 there were 21 failures (10.9%); but not all of these were the same children who had failed the test some 4 or 5 years earlier. The following table sets out the details.

Analysis of 193 Children Tested both in 1962/63 and 1967

Number of children who passed "sweep" test in 1962/63 and 1967 (i.e. deafness not suspected)	142
Number of children who passed "sweep" in 1962/1963 but failed in 1967 (i.e. now suspected to be deaf)	10
Number of children who failed "sweep" in 1963 but passed in 1967	30
Number of children who failed "sweep" in both 1962/63 and 1967	11

All of the 30 children who had failed in 1963 but "passed" in 1967 had been followed up carefully since 1963 until such time as it was considered that no further tests or treatment

were necessary. The 11 children who failed on both occasions were already attending the Audiology Unit and/or an otologist. 8 of the 10 children who passed the "sweep" in 1963 but failed in 1967 were already attending the audiology clinic having been referred either by school medical officers, the two peripatetic teachers of the deaf, a school teacher, general practitioner or parent. There were 2 children with a hearing loss who were not already under surveillance; neither of these had a hearing loss greater than 40 dbs. in either ear at the time of testing, and only isolated frequencies were affected, the loss being unilateral in one child and bilateral in the other; measles was possibly the causal factor in both. Subsequent inquiry and audiometric and verbal testing indicated that it was unlikely that either child was suffering from a loss sufficient to interfere with his educational progress.

Comment

In many areas throughout the country there is a strong case to be made for the introduction of a second audiometric "sweep" at age 9 years, since by this age a large number of children will have suffered from either isolated or recurrent ear infections and whereas they may have passed the 5 year old "sweep" many may have suffered an undiagnosed hearing loss, as is common, after the 5th year and before the 9th, and unless full audiological diagnostic facilities exist it is felt that many of these children will remain undiagnosed and untreated. If, however, the pilot scheme is representative of the whole area, it indicates that in Exeter the cover provided by a higher than average medical staff/children ratio and by the introduction and development of full audiological services, together with the use of selective medical examinations and of systematic review of weekly health returns from head teachers, and the close liaison existing between the schools and the School Health Department appears to obviate the need for the introduction of a 9 year old "sweep" test.

Employment

The Rev. W. B. J. Brown has been appointed welfare officer of the deaf and attended the final assessment clinic of children who are leaving the Royal School for the Deaf, and partially hearing children in the ordinary schools in the city. He maintains a close link with the youth employment officer and thereby provides a useful service in following-up these children, both in regard to employment opportunities and their general social relationships. Arrangements have already been made for these children living in Exeter to have access to regular audiometric testing and revision of their hearing aids. Mr. Roy Darche, senior hearing aid technician at the Royal Devon & Exeter Hospital, has again proved most helpful with respect to the provision of and advice upon commercial hearing aids as well as the Medresco hearing aid.

DEAFNESS IN SCHOOL CHILDREN—1967

Observations by Miss M. M. Godsland (Senior Peripatetic Teacher of the Partially Hearing)

We have two peripatetic teachers of the deaf: Miss M. M. Godsland spends 10% of her time on clinic work and 90% on teaching, about a third of this time being on pre-school work. Since Easter, 1967, Mr. D. G. G. Robinson has spent 40% of his time in ordinary schools and 60% in the Royal School for the Deaf studying for the Diploma in teaching the deaf, which he hopes to obtain in April, 1968. Most clerical work and visits to parents have been done out of school hours.

Testing

Testing is done by the two audiometricians, Mrs. M. B. Chubb, who works full time, and Mrs. P. E. D. Roberts, who works part time.

All school entrants in Exeter are given a quick screening hearing test during their 2nd term in school. Only one deaf child was newly discovered, and he had not been tested as a baby; he showed a moderate bilateral loss, probably catarrhal in origin.

Most children with moderate or severe bilateral hearing loss seem to be already known to us at school entry; they have already been tested as pre-school children, either through being on the "at risk" register or having been referred by parent, doctor, health visitor, teacher, etc. This fact points to an efficient pre-school service.

Routine screening tests of school entrants have been going for three years; the number of children requiring regular re-testing will therefore expand each year. If we are to maintain the high standard of testing that has already been established in Exeter, it is very necessary to have testing done by persons who are good at handling children in a test situation, and who have the necessary knowledge and experience to "weigh up" the child who feigns deafness, or makes odd responses or has a specific auditory interpretation difficulty, and who will refer these children to a teacher of the deaf or school medical officer for further investigation.

All "inward transfers" are tested. Others are tested at the request of school medical officer, head teacher, parent, etc. In these cases information about the state of hearing is usually passed back to the person who made the request.

The children regularly tested fall broadly into the following categories defined by degree of hearing loss:—

(i) *conductive losses* of (a) minimal degree (about 30-40 db.), (b) moderate degree (about 40-50 db.) or (c) moderately severe degree (about 50-70 db.), any of which may be "catarrhal temporary", or "persistent and fluctuating" or "permanent".

(ii) *perceptive losses* of (a) moderately severe degree (50-70 db.), (b) very severe degree (70-85 db.), (c) profound degree (85-100 db.) or (d) sub-total (i.e. with residual islands of hearing at 95-100 db.). The audiograms of these in group (i) (a), (b) or (c) may be "flat" or show a greater loss for the high frequencies. Children in group (ii) (b), (c) or (d) are ordinarily taught in schools for the deaf; we test these at our annual review.

The effect of hearing losses of varying degrees are roughly as follows:—a child with a minimal to moderate loss can only hear for a limited distance, probably ranging from 6-12 feet. A child with a moderately severe loss can generally only hear at distances of 2-3 feet and needs to rely on lip-reading; hearing aids can extend the hearing distance but their use is often limited in excessively noisy surroundings, and location of the source of sound is not possible. Children who are deafer than 70 db. loss always need to rely on lip-reading, as their main means of understanding others. No hearing aid, however powerful, can make sound very meaningful to a child with a loss in the region of 90-100 db.

The great majority, probably as many as 90% of children tested, have only minimal losses and are regularly tested in case their hearing deteriorates.

Children whose loss is persistent and fluctuating can present a very conflicting picture; some days they can hear, other days they cannot. These are the type of children who appear to be "putting deafness on"; in fact, their hearing is varying, quite often to an enormous degree even as much as 50 db. of loss, though a more general variation would be in the region of 20-50 db. The child with this type of loss can often be helped by surgery, or by natural improvement in a catarrhal condition, as he grows older, but in the meantime, he misses a lot in school and is often misunderstood. Whilst awaiting surgery, he may need to sit at the front of the class to receive help with lip-reading, or even to use a hearing aid temporarily.

Children with a significant loss of hearing are referred to the audiology clinic for further examination and, from there, are generally referred for special treatment.

The group of children with perceptive losses usually need hearing aids and special help with lip-reading, speech and basic subjects.

All audiograms prepared by the audiometricians are seen by the peripatetic teachers. Children whose audiograms fall below a level of 30 db. at two or more frequencies, are re-tested. Children having once been regarded as somewhat deaf are not generally cleared until there have been two or three normal audiograms. Children whose hearing level has been shown to drop in winter are sometimes intentionally re-tested then rather than at other times of the year.

A considerable number of children is given tests of hearing for speech by the peripatetic teachers of the deaf at their schools

or, preferably, in the audiology clinic. These tests are useful if a child's hearing varies, if he has a specific language difficulty in hearing and interpreting speech; or if he "shuts off" for psychological reasons.

Use of the Clinic

At the audiology clinics, held twice monthly, the teacher of the deaf co-operates with the school medical officer, tests hearing for speech, assesses the need for hearing aids, comments on educational progress and on difficulties or needs inherent in the handicap, or answers questions and gives advice to the mother. Follow-up can involve visits to school or home to give help.

All children classified as deaf or partially hearing, are seen annually at the clinic.

At this examination the school medical officer responsible for deaf and partially hearing children examines them medically and the audiometricians test the children's hearing. The teacher of the deaf checks earmoulds and hearing aids and does tests of ability to hear speech. In some cases different types of hearing aid are recommended and a number of children have been sent to the hospital's hearing aid department to have new impressions taken for earmoulds.

Other problems are discussed, relating to transport, education management, employment, etc.

Many parents are already anxious about the problem of employment, although their children are only 12 or 13 years old. There is a need for guidance to be given at a much earlier age than at present, for often the parents start seeking information on occupations which may prove unsuitable for the particular child.

The clinic has also been used quite a lot for speech tests, and initial auditory training when a child first has a hearing aid, as quiet, sound-proof surroundings are an advantage for this type of work. As the clinic is central, it has been used to some extent for work with small groups from different schools, who have similar needs, including backward readers, lip-readers and school leavers.

Hearing Aids

Although 4 children were provided with hearing aids for the first time during the year, the number of school children using hearing aids dropped from 48 in 1966 to 37 this year; 4 left school, 1 left Exeter and 10 aids were withdrawn as no longer being needed.

A few children have had hearing aids issued for a temporary period, whilst awaiting surgery, and others use aids temporarily, when their hearing deteriorates. This can ensure that a child with a fairly severe deafness is not "missing out" educationally.

Seven powerful body-worn commercial aids have been issued this year to children who have severe or profound hearing loss or who have severe high frequency losses or whose tolerance of amplification is low. Several commercial aids have been issued to profoundly and sub-totally deaf Exeter children who are attending the School for the Deaf and whose degree of loss is so severe that a National Health Medresco aid is not sufficiently powerful.

Six children have had post-aural aids issued. Most of the children concerned have almost completely refused to wear their Medresco aids because of auditory discomfort or self-consciousness, but who are now wearing the new aids, either because they are better suited to their type of deafness or because of their inconspicuousness.

We have had full co-operation and help from the Hearing Aid Department of the Royal Devon & Exeter Hospital regarding the issue of aids, the making of new earmoulds and the supplying of spares. A few children, mainly infants, could benefit from use of speech training units in the home.

Numbers of Children

(i) In Ordinary Schools

The majority of children receiving follow-up tests have practically normal hearing and are not necessarily seen by the peripatetic teachers of the deaf. Children for whom the peripatetic teachers of the deaf are mainly responsible have losses ranging from about 40-45 db. to about 55-70 db., but most fall into the range 40-60 db. There are also, apart from these, a few children who have deafness in one ear or fluctuating losses who are seen occasionally by the teachers of the deaf.

Where a child has a bilateral loss roughly in the 40-60 range, he is sometimes under observation in order to be sure that he is keeping up satisfactorily with his schooling, to check on his use of the hearing aid, and his class positioning. There are 49 children (2 infants, 21 juniors, and 26 seniors) falling into this category of hearing-loss, 37 of whom have hearing aids. When it is apparent that the child requires some help, he has visits from the peripatetic teacher of the deaf weekly or occasionally more often. At present Mr. Robinson sees 12 of these and Miss Godsland 23 weekly; the remaining 14 are visited as and when required.

(ii) In Special Schools etc.

There are 22 Exeter children attending the Royal School for the Deaf, Exeter, including 2 in the nursery; 8 of these are sub-totally deaf; 7 profoundly deaf; 2 severely deaf, and 3 partially hearing; the other 2 have been diagnosed as non-communicating for other reasons and they are awaiting further examination or placement elsewhere. There is also one Exeter child at the Torquay Senior Partially Hearing Unit and 2 deaf

physically handicapped children at Dame Hannah Rogers School for Spastics, Ivybridge.

The number of severely and profoundly deaf children in Exeter is larger per head per population than is recorded in most places. One reason for this is that it is known that several families have moved into Exeter so that their children may be day pupils of the school and have the advantage of a normal home environment and communication with hearing people.

Teaching

Of the children seen regularly, most are seen weekly for about half an hour to an hour and a few twice or even three times a week for shorter periods, these latter mostly being younger children. There are 35 children being seen regularly at present : 9 infants, 14 juniors and 12 seniors.

Sometimes children are given intensive help over a short period : for instance when an aid is issued, when help in lip-reading or speech is given or when short-term remedial work is undertaken. Other children receive remedial help on a long-term basis in one or more subjects, the emphasis sometimes varying. Some partially hearing children need this "support teaching" and through most of their school days. A few authorities use retired or part-time teachers to help the teachers of the deaf and supplement this side of their work.

At the infant level most help is required in the areas of language, speech, lip-reading and auditory training.

At all levels a lot of work is concerned with help in basic subjects, particularly in English, reading and number. The partially hearing child often needs help in extending his vocabulary, in sorting out the meanings of words and colloquial English which he misunderstands through hearing in a blurred and patchy manner. He also often "misses out" on early fundamental teaching of sounds and number bonds for the same reason. Most work with these children concentrates on easing the limitations of communication and language.

At the senior level, most of the work is concerned with finding out from the child what his difficulties are and helping with particular problems which may vary from week to week. Effective follow-up is much more difficult as the child has many different teachers, and the wearing of an aid, and finding a good position for lip-reading in each lesson largely depends on the child himself.

A certain amount of the school work involves following up children in whom deafness is suspected, assessing their needs and informing the class teacher and headteacher—this is particularly important where a hearing aid is issued or where the deafness varies.

Group teaching would appear to be a way in which the peripatetic teacher of the deaf could save duplication and make more time available. In practice, this has been tried and found

to be exceedingly difficult, as the numbers of hearing handicapped children in most schools are too small to find children at the same level and with similar needs ; if groups of children were in a few schools, this would be simpler. Use of the Audiology Clinic as a centre make it possible to bring a small group together, though some time is then spent in transporting children. Use of tapes can make an approach individual and overcome the problem of using different books in a subject like reading. Powerful amplification in quiet surroundings is also valuable.

Parents

The frequency of visits to parents varies greatly according to the need at the time. More concentrated support is necessary when a child is issued with an aid or when there is some specific adjustment or emotional problem in the child or home. Other visits can be just routine keeping in touch or giving help over management, encouraging the child to play, read or develop language.

In the case of deaf children attending the Royal School for the Deaf, Exeter, and other schools and units, visits have been made in the holidays for routine ear mould and hearing aid checks. When new hearing aids have been issued, there has been follow-up both at home and at school, to determine their effectiveness.

At other times parents have been visited just routinely and this often gives the parent who feels worried or isolated a chance to unburden herself. Other visits have been made at the request of either the school or parents over some particular problem.

Parents' meetings may perhaps be started later in the New Year 1968. The main difficulties are in knowing what parents want and in catering effectively for a very mixed group.

This is an aspect of the work of the peripatetic teacher of the deaf which will probably be more effectively covered when we have two full-time teachers.

Other Comments on the Partially Hearing Child

(i) *The Child with a Minimal to Moderate Loss*

There is a considerable number of children in Exeter with a minimal to moderate hearing loss, who are handicapped to a surprising degree by a relatively minor degree of deafness.

Quite often this type of child has other handicaps and the combination can be equivalent to a more severe impairment in one sphere. For instance, if a child has a low I.Q. his ability to adapt and adjust quickly to concentrate and compensate are lessened and he does not overcome a minor handicap as effectively as a more adaptable, brighter child. Home environments which are emotionally unstable and/or materially deprived ; repeated serious illnesses or generally poor health ; a specific language-learning or listening interpretation difficulty can all accentuate the effect of a lesser deafness.

This child, with a minimal moderate defect does not usually get regular help from a peripatetic teacher of the deaf, though his hearing is watched. But he often has two special needs: (i) for speech therapy, to correct minor speech defects, and (ii) for concentrated remedial help in basic subjects in a small group, as often as possible. This type of child suffers at present because of the shortage of speech therapists and the consequent long waiting period of six months or usually longer before treatment, and because of the enormous pressure on the class teacher and on special remedial facilities, such as Mrs. Cornish's reading group at the Child Guidance Clinic.

(ii) *The Child who has had a catarrhal deafness in the past and whose hearing is now normal*

This type of child often needs extra remedial help in basic subjects. At present there is a certain "backlog" of these children, whose deafness was not discovered when they were younger. Many no longer fall into the category of hearing-impaired children getting peripatetic help as their hearing is now normal, but they do have a retardation stemming from a hearing loss in the past.

This kind of situation will, we hope, be avoided to a large extent in the future, now that school entry testing is done and peripatetic follow-up is possible.

(iii) *The Severely Partially-Hearing Child and the Child with Progressive Deafness*

A suggestion has been made that certain children should attend the Department for the Partially-Hearing at the Royal School for the Deaf either for one morning or every morning per week.

The first suggestion, I feel, would provide an unnecessary service, as this type of help is already given by the peripatetic teachers.

I view the second suggestion with considerable concern, as I believe it would be a rare child who could successfully adjust to two such contrasting school atmospheres, standards, methods and approaches, and as would be provided by an ordinary school and a special school for hearing-handicapped children. I think this is particularly so in the case of younger children.

Apart from this, to be really effective, *very* close liaison between the schools concerned would be necessary and would appear to be well nigh impossible when children would be coming from schools scattered all over the city. There would also be

very great difficulty in synchronising timetables of various schools in order to achieve a balance of subjects. Transport would also present a problem.

Another point to consider is that the partially-hearing children, at present placed in ordinary schools in Exeter, do not need the concentrated language learning, which is the speciality of a school for the hearing handicapped. These children with very few exceptions, have standards of language and communication which are normal or near normal.

No doubt these suggestions have arisen because of the very real need of a few children to have some kind of intermediate provision. There are, for instance, children whose parents refuse education in special schools when it is offered even though the child needs it; secondly, children who have normal speech, language and educational standards, but who suffer from progressively worsening hearing or sudden deafness and the consequent "missing out" in lessons, for whom special school placement would be quite unsuitable, and also children who are ideally suited for ordinary schooling from a social and communication angle and yet who, we know, are "missing out" on certain aspects of the curriculum, because of a more severe degree of hearing loss. In some authorities these children are catered for by unit provision, where a special class is attached to an ordinary school and where the child can be in an ordinary class and yet receive concentrated, specialised, remedial help as and when necessary.

As we have no units, a choice will continue to have to be made between the alternatives—ordinary and special schooling (for deaf or partially hearing) neither of which quite cater for this child's need, but I am convinced that a placement in one educational establishment is better than movement to and fro between two schools, whatever the educational and/or social limitation may be for the child concerned. I also think it is important to view short-term temporary placement in the Department for the Partially Hearing at the Royal School for the Deaf, with caution, as stability is an important need of any handicapped child.

VISION

The School Eye Service is provided by the West of England Eye Infirmary, one session a fortnight (18 attendances) being reserved for our school children.

483 children were referred by the school medical officers during the year. 227 of them (101 boys; 126 girls) were referred

for the first time ; spectacles were prescribed for 125 of these last (56 boys ; 69 girls). The usual visual standard for reference is 6/12 in either eye, unaided. The age groups of the 227 children sent to the Eye Infirmary for the first time is set out below :

Year of birth	Number Referred	Spectacles Prescribed
1962/63	12	7
1961	27	17
1960	28	14
1959	18	8
1958	24	16
1957	14	6
1956	17	11
1955	30	20
1954	21	10
1953	22	13
1952	7	2
1951	5	1
1950	2	—
TOTAL	227	125

In addition to the 256 "old cases" referred by us, 62 children attended without appointment ; 47 had new lenses prescribed. Also during the year 209 (85 boys ; 124 girls) were noted for the first time as attending private opticians. The corresponding figure for 1966 was 229 and for 1965 was 142.

SQUINT

During the year 14 new cases of squint (9 girls ; 5 boys)—an exceptionally high number for Exeter—were found, in the age range of 3 to 7 years. 10 were referred to the Eye Infirmary and confirmed and 4 are being kept under observation. 2 of the children had come here from outside authorities. Analysis of these cases has not shewn any undue delay in ascertainment.

Vision Examination of 5 Year Old Children

Of 1,105 five-year-old children tested during their medical examination as entrants, 185 (97 boys ; 88 girls) were found to have some degree of defective vision ; of these, 26 already had spectacles and were under regular observation at the Eye Infirmary ; 9 were referred to the Eye Infirmary for further investigation (spectacles were prescribed for 7 of them) ; the rest are being kept under observation.

Vision Examination of 13 Year Old Children

Of the 415 children tested during the periodic medical examination in their fourteenth year, 48 (28 boys ; 20 girls) already had spectacles ; 36 others (22 boys ; 14 girls) had some degree of defective vision, of these 34 are being kept under observation and 2 were referred to the Eye Infirmary ; spectacles were prescribed for 1 (boy).

In addition to these two groups the school nurses tested the vision of 4,233 children in the following age groups :

AGE	No. Examined	Normal	For Observation	Referred to Eye Infirmary	Spectacles prescribed	
					Boys	Girls
7 year olds	1,141	987	133	21	7	4
10 " "	1,014	864	128	22	6	8
12 " "	1,202	978	206	18	7	5
14 " "	876	711	157	8	1	3
TOTAL	4,233	3,540	624	69	21	20

COLOUR VISION

During 1967, the nurses, using Ishihara plates, tested 644 boys, mainly 10 year olds in their last year at junior schools. 65 were considered to be defective and were called to the central school health clinic for retesting by Dr. G. P. McLauchlan, with the Giles-Archer Lantern ; 29 were found to be " unsafe ". The table below sets out the results of the tests. All the 6 children remaining untested from 1966 were investigated this year and 4 were found to be " unsafe ". We have not examined the girls since 1958, as defective colour vision is so rare among them. No suspected cases of defective colour vision in girls have been referred from the schools.

COLOUR VISION

(BOYS)

ISHIHARA TEST RESULTS				1967	6 years 1962-67 Summary
Number examined (Ishihara tests)				644	3,672
Number found to have defective colour vision				65	275
Inconsistent ....	....	....	} Giles Archer Lantern Test	8	25
Green Defective ....	....	....		33	109
Partially Green Defective ....	....	....		12	47
Red Defective ....	....	....		1	26
Partially Red Defective ....	....	....		2	6
Red-Green Defective ....	....	....		1	11
Partially Red-Green Defective	....	....		—	1
Found to be normal ....	....	....		2	3
Did not attend ....	....	....	....	5	46
Left Exeter Area ....	....	....	....	1	1
TOTAL				65	275
UNSAFE				29	127

OPERATIVE TREATMENT FOR ADENOIDS AND CHRONIC TONSILLITIS

185 children (85 boys; 100 girls) in maintained schools were known to us to have had their adenoids and/or tonsils removed in 1967, i.e. 1.6% of the school population.

TONSIL AND/OR ADENOID OPERATIONS, 1967

<i>Age at Operation</i>			<i>Boys</i>	<i>Girls</i>	<i>1967 Total</i>	<i>1966 Total</i>
Under 6 years	....		25	17	42	40
6 years	...	....	21	20	41	51
7 "	...	....	12	24	36	38
8 "	..	....	12	11	23	28
9 "	....	....	4	10	14	16
10 "	...	....	3	3	6	16
11 "	...	....	3	4	7	9
12 "	...	....	3	2	5	6
13 "	....	....	2	5	7	9
14 "	....	....	—	4	4	3
15 "	....	....	—	—	—	—
TOTAL						
			85	100	185	216

REPORT OF THE PRINCIPAL DENTAL OFFICER YEAR ENDING 31st DECEMBER, 1967

(Alvin Pryor, L.D.S., R.C.S. (ENG.))

The school dental service in Exeter has shown another year of steady progress. No change occurred in the dental operating staff, which remains at full establishment (four dental officers). This is not due solely to the undoubted attractions of Exeter and the County, as many of the younger dental surgeons consider the South West too remote from the great cities for their liking. It is therefore cause for considerable satisfaction, as many authorities find it a constant worry to recruit and retain their dental officers. There has been one change among the dental surgery assistants, Miss M. J. Langworthy resigning in November, after two and a half years' service, to take up a different occupation. She was replaced by Miss J. I. Full later in the month.

The equipment in No. 2 surgery at Southernhay West was modernised in the spring with a new dental unit. Two new anaesthetic machines were installed, and the safety requirements of the Ministry of Health, as set out in the recent Report on Dental Anaesthesia, are satisfied fully. One cannot take any risks with general anaesthesia, of which we do a great deal.

Two dental officers attended courses in children's dentistry in London during the year, Mr. T. N. Praat (St. Thomas Clinic) in April, Mr. R. B. Mycock (Whipton Clinic) in June. Both feel they have benefited greatly from these courses, which, in turn, improved the service we can offer. I attended the Annual Conference of the British Dental Association at Birmingham University in July; I found it the most interesting and informative Conference I have ever attended, and of great value.

I hope that when conditions allow, the dental officers will be permitted to go on courses more frequently than at present, as it is the best way to keep abreast of modern developments. Reading of professional journals helps in this, but it is not sufficient.

While on the subject of courses, I would like to mention the evening courses held at the Exeter Technical College for dental surgery assistants. These courses continued through the spring and autumn, the ultimate aim being the obtaining of the Certificate of the British Dental Nurses Association after a stiff examination. The courses are conducted by local dental surgeons in conjunction with the staff of the College. I am a member of the organising committee and arranged two practical "test" examinations for the students during the year at the Southernhay clinic. I am very pleased to report that Miss D. J. Freeman, dental surgery assistant at St. Thomas clinic, was successful in obtaining the coveted certificate. Until Miss Langworthy's resignation in November, all my dental surgery assistants were in possession of this certificate. It takes a lot of "stick-to-it-

iveness " on the part of these students, and praise is due to those who " stay the course ".

Liaison with the general dental service was strengthened by my being elected as school dental service representative on the Local Dental Committee for Devon and Exeter. Surgery accommodation for the examination of dental patients was made available to the regional dental officers of the Ministry of Health on several occasions during the year. The Executive Committee for Devon and Exeter also had the use of the Countess Wear clinic for a complete afternoon for a hearing of dental cases. These facilities have been greatly appreciated, as this type of accommodation is unobtainable elsewhere in the city.

Dr. N. G. P. Butler, consultant anaesthetist, attended weekly throughout the year for dental anaesthetic sessions, continuing to use the well-proven 20% oxygen to 80% nitrous oxide method which he helped to introduce into this country, as mentioned in my previous reports. The patient breathes the equivalent of atmospheric oxygen during the whole of the operation, so that the safety factor is very high. The absence of unpleasant post-anaesthetic sequelae is a cause for favourable comment ; recovery is rapid and complete.

This is, of course, entirely attributable to the brain being supplied with adequate oxygen—the dangers of damage to the brain tissue inherent in the older methods of oxygen-restriction (when the patient used to have to be " nice and black " before extractions commenced) being entirely eliminated.

An encouraging aspect of the foregoing is that several Exeter doctors, who have been welcome visitors to our extraction sessions, have adopted this technique themselves. I made a 15-minute 8 mm. colour film, privately, of one of our anaesthetic sessions, which has been shown to gatherings of doctors and dentists.

Mr. R. B. Mycock, dental officer, continued his regular weekly general anaesthetic sessions throughout the year, holding these on alternate weeks at the Whipton and St. Thomas Clinics.

The other dental officers and I give general anaesthetics for each other as required. We also have a local " panel " of medical practitioners skilled in the use of general anaesthetics, upon whom we call for the emergency administration of general anaesthetics for pre-school children. This has proved of immense value. We claim a complete coverage for the relief of pain, no patient having to wait for more than a few hours, at most, for a general anaesthetic. Even this delay is, more often than not, caused by having to wait the necessary time for the patient to digest the last meal.

We have, in these arrangements, a considerable advantage over the general dental practitioner, so often working single-handed.

We do, in fact, frequently treat children in pain who have already been taken to local dentists who are unable to treat

them for some time—some weeks in certain cases. Some of these dentists request us to see such emergency cases—and we are, of course, happy to oblige them.

Mr. Maurice Burley, consultant orthodontist, attended at intervals during the year, as required. Mr. Burley's advice, given in a friendly and informal manner to the dental officers, and his tactful approach to patients, are greatly appreciated. He treats the cases which need prolonged fixed-appliance therapy in his own clinic in the Royal Devon & Exeter Hospital. The dental officers diagnose and treat the more usual orthodontic cases themselves, of course.

All the maintained schools in the city received dental inspections during the year, and to these were added the inspection of the new Southbrook School. St. Margaret's School, a large private school for girls, requested the facilities of the school health service, the school dental service being a part of this. Of the 254 inspected, 89 were found to require treatment. A large proportion of the children received two, frequently three or four dental "check-up" examinations during the year. I like to see children at least every four months—in this way, any maintenance treatment is usually of a very minor order.

We do not trouble the schools with more than one annual inspection per year; these extra inspections are carried out at the school clinics, the patients being recalled for this purpose.

And at this point I would like to express my appreciation of the co-operation shown to us by the head teachers and their staffs, which makes our work so much easier. It is appreciated that dental inspections *are* an intrusion into and a slight disruption of school life, but we aim to make our visits as short as possible commensurate with thoroughness.

We are continuing to inspect the trainees attending the Nichols adult training centre, and a few have attended for treatment. We also treat from time to time Exeter children who attend schools outside the city, when requested by their parents. Often these are children who in the past attended city-maintained schools, but who now go to boarding schools in other areas. Such children are seen in their holidays. Other children in this category now attend private schools within the city. But children attending the maintained schools naturally receive priority in treatment.

The Countess Wear clinic, opened last year, is proving useful to those schools which it serves. We wish we could see more of the Topsham children there, as it was opened partly for their benefit.

The condition of the teeth of Exeter's schoolchildren continues to improve, there is no doubt about this. There is, on average, much less to do for each child, per course of treatment, than hitherto. This is due to the great amount of dentistry done for the children each year both by the school dental service and the

large number of dentists practising in the city. If only we could have fluoridation of Exeter's domestic water supply, to help us in our work, we would really feel confident we had got dental decay licked. This latter aid, however, remains but a pious hope.

And finally, a warm commendation to my dental officers and staff, who have worked willingly and well throughout the year. I feel I have a very good team here, for which I am grateful.

Dental Inspections

The number of children inspected in school was 11,482. Of the 1,331 inspected at the clinic, 632 were emergency cases. Those recalled for "check-up" and mentioned earlier numbered 657, of whom 530 were found to require treatment. Also (not included in the table) 40 children were examined in the Ellen Tinkham House School, 15 of whom were found to require treatment.

Treatment

The number of teeth filled in 1967 was 3,521; 790 children had their teeth scaled; 3,143 teeth were treated with silver nitrate and 106 were X-rayed.

Orthodontia

Children considered suitable receive this treatment. 12 new cases were commenced during the year. At the beginning of the year 245 cases were being treated, and 76 were completed or discontinued during the year, leaving 181 still under treatment at the end of 1967.

Dental Clinics	Attendances		
	1965	1966	1967
Central Clinic, 1a Southernhay West	3,874	4,388	3,627
Whipton Health Clinic	2,142	1,965	2,065
St. Thomas Clinic	2,377	3,014	2,473
Countess Wear Clinic	—	—	517
TOTALS	8,393	9,367	8,682

Age Distribution of Children Inspected and Referred.

Age in years.	Udr. 5	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	Total
No. inspected in schools	56	671	1151	1101	1170	1133	1097	1006	947	976	859	752	320	167	60	16	11,482
No. referred for treatment	16	312	632	595	607	594	565	468	407	454	391	318	121	52	15	4	5,551

CLEANLINESS

The number of head cleanliness inspections during 1967 was 8,371 (11,115 in 1966); 85 children (17 boys; 68 girls) were found unclean, i.e. verminous with nits or lice, compared with 79 in 1966 and 82 in 1965. 24 of the children had been found verminous during the previous year. The overall rate for 1967 was 0.66% (0.25% among the boys and 1.1% among the girls) compared with an overall rate of 0.63% in 1966 and 0.72% in 1965. No compulsory cleansing orders were made nor were any prosecutions undertaken.

TABLE SHOWING INDIVIDUAL CASES OF UNCLEAN (VERMINOUS) HEADS FOUND IN 1967 BY AGE GROUPS

AGE (at 31.12.67)	CHILDREN WITH HEADS FOUND UNCLEAN					
	TABLE A.				TABLE B. No. of Children in Table A. also found Unclean in 1966	
	ONCE ONLY		MORE THAN ONCE		Boys	Girls
	Boys	Girls	Boys	Girls		
Under 5 years	1	3	—	—	—	—
Aged 5 "	—	5	—	—	—	1
" 6 "	1	6	1	2	1	2
" 7 "	3	7	—	2	—	2
" 8 "	5	7	—	1	—	2
" 9 "	3	8	—	2	1	3
" 10 "	1	7	—	5	1	6
" 11 "	—	5	—	1	—	2
" 12 "	2	2	—	1	1	—
" 13 "	—	—	—	1	—	1
" 14 "	—	—	—	1	—	1
Over 14	—	1	—	—	—	—
TOTAL	16	51	1	16	4	20

TOTAL IN 1967 : 85 = 0.66% of school children.

SCHOOL CLINICS

The Eastern Clinic (Burnthouse Lane) was open every school morning as a minor ailment clinic. The Central Clinic was open on Mondays and Thursdays throughout the year, mainly as a consultation clinic with a doctor. A considerable number of special cases (including enuretic children, fitness for employment cases, etc.) attend, generally by appointment (not included in the table below). Since January, 1968 the Monday central clinic has been abandoned in favour of a clinic at Whipton, which enables children in the Northern area of the city to attend with the minimum loss of school time.

As from October it was not possible to continue the doctor's weekly attendance at the Eastern clinic.

The location of the school clinics and the attendances were as follows :—

	<i>Minor Ailments— Attendances</i>		
	1965	1966	1967
Central Clinic, 1a Southernhay West	387	287	233
Eastern Clinic, Burnthouse Lane Community Centre, Shakespeare Road	2,406	2,160	1,939
TOTALS	2,793	2,447	2,172

**TABLE SHOWING THE INCIDENCE OF MINOR AILMENTS
TREATED DURING 1967 IN CLINICS**

DEFECT	*Central Clinic	Eastern Clinic	GRAND TOTAL 1967	GRAND TOTAL 1966
Scabies	—	1	1	—
Ringworm : Scalp	—	—	—	—
Body	—	—	—	—
Eye Defects (not visual)	4	54	58	88
Ear Defects—(including wax, otorrhoea, etc.)	13	36	49	57
Nose and Throat Defects	—	23	23	42
Impetigo	3	9	12	6
Warts : Plantar	65	51	116	71
Other	19	20	39	42
Other skin conditions	4	68	72	103
Minor Injuries	4	139	143	164
Miscellaneous	7	196	203	219
Total No. of individual children	119	597	716	792
Total No. of attendances	233	1,939	2,172	2,447
Total No. of sessions	253	206	456	456

* At this clinic many cases are seen as consultation cases, not included here.

When a child has been treated at the one time for more than one defect or disorder the more important has been listed.

In addition, school children are seen by the doctor at the Countess Wear Welfare Clinic after school hours on Mondays, as and when necessary. During the year, 14 children made 22 attendances at the clinic. Though it is said the incidence of scabies is increasing, there is no evidence of it yet here.

**TABLE SHEWING THE NUMBER OF HANDICAPPED
PUPILS IN SPECIAL SCHOOLS OR HOMES AS AT
18th JANUARY 1968**

DISABILITY	Total No. of children classified as handi- capped as at 18-1-68.	SPECIAL SCHOOL OR HOME	RESID.		NON RESID.		Total No. of children attending Special Schools or Homes	Total No. of children awaiting admission to Special Schools or Homes
			B.	G.	B.	G.		
BLIND	2	Royal School for the Blind, Bristol Worcester College for the Blind, Worcester	—	1	—	—	2	—
			1	—	—	—		
PARTIALLY SIGHTED	4	West of England School for the Partially Sighted, Exeter	—	—	3	1	4	—
PARTIALLY HEARING	69	Mary Hare Gram. School, Berks. Summerfield Hse. Sch., Malvern, Worcs. Royal West of England School for the Deaf, Exeter	—	1	—	—	24	—
			1	—	—	—		
			—	2	9	11		
PHYSICALLY HANDICAPPED	21	Dame Hannah Rogers Sch. for Spastics, Ivy- bridge Bruce Porter Hse. School, Taunton, Somerset Heathercombe Brake School, Manaton Ingfield Manor School, Sussex	2	—	—	—	5	—
			—	1	—	—		
			1	—	—	—		
			1	—	—	—		
EPILEPTIC	47		—	—	—	—	—	—
EDUCA- TIONALLY SUBNORMAL	217	St. Christopher's School, Bristol Withycombe Hse. Special Sch., Exmouth, Devon Kingsdon Manor School, Nr. Bristol Pitt House, Chudleigh Pitt House, Torquay Clyffe Hse., Dorchester Maristow Hse., Plymouth Bradfield Sch., Cullom- pton Hassobury Sch., Essex Southbrook Sch., Exeter	—	1	—	—	128	76*
			—	7	—	—		
			2	—	—	—		
			4	—	—	—		
			8	—	—	—		
			1	—	—	—		
			—	1	—	—		
			2	—	—	—		
			—	1	—	—		
			—	—	53	48		
DELICATE	31	Heathlands Rise, Teign- mouth Heathercombe Brake Sch., Manaton, Devon Pilgrims School, Sussex	—	4	—	—	17	1
			12	—	—	—		
			1	—	—	—		
MALADJUSTED	58	Pitt Hse. Sch., Torquay Stella Maris Convent School, Bideford Cam House School, Gloster Grenville College, Bideford, Devon St. Francis Sch., Dorset Leigh Court Sch., Devon Royal Alexandra and Albert School, Surrey The Gables Hostel, Willand, Devon Crichel Hostel, Devon Sandford Orleigh School, Newton Abbot, Devon Farnley Close, Sussex	1	—	—	—	14	1
			—	1	—	—		
			1	—	—	—		
			1	—	—	—		
			1	—	—	—		
			—	1	—	—		
			1	1	—	—		
			1	—	—	—		
			1	2	—	—		
			—	1	—	—		
DEFECTIVE SPEECH	224		—	—	—	—	—	—
TOTAL	673		44	25	65	60	194	78

*75 of these children recommended admission to a Day Special School.

SOUTHBROOK (DAY) SCHOOL FOR E.S.N. CHILDREN

This new school was opened on 5th April. Mr. D. S. Kerr (headmaster) has kindly sent me these notes.

REPORT ON SOUTHBROOK SCHOOL, 1967

In the first term, we admitted 82 children from Exeter and Devon.

On the 5th September, the remainder of the complement was admitted making the school full from that date, 138 at the end of the year, including 97 Exeter children.

The range of intelligence quotients is from 47 at the lowest to 83 at the highest, with the peak of the graph occurring as expected, within the 65-75 bracket. Some of the children with lower I.Q's are only doubtfully suitable for this school and must be carefully observed during their first three terms.

There are a great number of children with multiple handicaps, including a dozen with epilepsy (major or minor), some 40 children with speech defects requiring therapy, one phenylketonuric, 3 asthmatic, and several with mild spasticity of varying degrees : there are many children with fairly severe hearing loss, two of whom have to wear hearing aids permanently.

In the main, all the children have succeeded in integrating well into the school activities, both physical, recreational and academic. Swimming is encouraged and even during the winter caters for 75% of the school population on a regular basis. Epileptics and others with major physical handicaps are contained within a special swimming group at the learners' shallow pool, the matron taking personal responsibility for their safety.

Parents, almost without exception, are enthusiastic about their children's improved attitudes to school and response to education, since their transfer to Southbrook School, and our attendance records substantiate this fact averaging as they do at 95% except when winter ailments strike hard.

NOTES ON MEDICAL CARE IN SOUTHBROOK SCHOOL

By Dr. E. L. Ryan

Southbrook School was originally planned to take 160 children (i.e. 100 from Exeter and 60 from Devon County) but during the year it was decided that the intake be limited to 140. In fact, 141 children were attending the school in December, 1967, including 103 from Exeter.

A school matron, with considerable nursing experience, but without formal nursing qualifications, was appointed to deal, day to day, with the children's health, and a health visitor/school nurse was attached to the school and visited weekly. I also visited once a week.

As most of the children were unknown to the medical officer, it was decided she should see and examine each child preferably accompanied by his/her parents.

Routine vision testing was carried out by the health visitor who also maintained the medical records, the record cards being filed in the school. All children were tested by an audiometrician and those who seemed to require it were seen by the peripatetic teacher for the deaf.

Number of children examined by the medical officer 120

Number of children awaiting examination in December, 1967 21

3 children who had been admitted ceased to attend : one, a severe epileptic, was transferred to the Junior Training Centre, one a known " non-attender " only attended 4 days and was later sent to a residential school, and one, from a residential special school came before the Courts and was readmitted to another residential school.

The headmaster was most helpful in accepting for a trial period, 4 children with various other severe handicaps. They were still in school in December, 1967.

Comments

1. Background and Family History

(a) *Mental Disorders*

24 had backgrounds of mental disorder, thus :—

11 children had both parents and siblings of low mentality.

3 children had one parent of low mentality.

7 children had one or more siblings of low mentality.

2 children had one parent who was mentally unstable.

1 child had a family history of mental instability (not parents).

(b) *Other Disabling Illness*

8 had other family history of disabling illness, thus :—

5 children had a family history of epilepsy, 1 of diabetes,

1 of asthma, and 1 of deafness.

2. Personal History

(c) *Family circumstance*

4 had had severe personal illness. 1 child had a history of phenylketonuria which had been treated by diet, 1 of meningitis, and 2 of encephalitis.

20 children (not included in the above figures) had a poor home background, e.g. parents separated, one parent dead, home dirty and neglected, etc. Nothing of any significance could be discovered in the family or past history of the remaining children—the enquiries, however, were not exhaustive.

(d) *Size of Family*

Of the 120 children examined, 28 were members of a large family (5 or more children).

3. Medical Examinations—Defects found

The following table gives a summary of the main defects found :—

Epilepsy 12 cases (all on medication)	Heart defect (1) Congenital heart murmur 1
Cerebral Palsy 8 cases	Lung Conditions (5)
Behaviour Difficulties 22 cases (6 of these have attended or are attending the Child Guidance Clinic)	Asthma 1 Bronchitis 4
Defects of Vision (38)	Orthopaedic defects 15
Corrected by spectacles 17	Overweight 11 (5 of these are on a special diet in school)
Referred for treatment 5	Other conditions (8)
Squint—treated by operation 5	Phenylketonuria 1 (on diet)
Nystagmus—attending Eye Infirmery 2 (1 of these is Cerebellar lesion)	Ulcerative Colitis 1 (has had ileostomy)
For observation—attending Eye Infirmery 9	Duodenal Ulcer 2 (on diet)
Hearing defects (14)	Anaemia 1 (under treatment)
Wears hearing aid 2	Psoriasis 1
For observation 12	Arrested Hydrocephalus 1 (hearing—observation)
Speech (24)	Mild degree of Hypospadias 1
Moderate to severe defect 20 (1 child says about 8 words. Not deaf)	
Slight defect 4	

Owing to staffing difficulties up to December, 1967 no speech therapist had been attached to the school. A number of these children would benefit from speech therapy and indeed some had been having it up to their admission to Southbrook School. However, this position has been remedied in the new year 1968.

A large number of children, not listed in the table, had postural defects of a minor degree. These would all benefit from suitable remedial exercises. The school was endeavouring to cope with this, but the supervision and advice of an expert would be helpful.

4. Intelligence quotient range was as follows :—

I.Q.	Number
Below 50	3
50—59	19
60—69	54
70—79	62
80—89	3

REPORT BY EDUCATIONAL PSYCHOLOGIST, 1967

(D. J. Thomas, B.A., DIP.ED.PSYCH.)

The most significant development in the School Psychological Service in the last year has been the part-time appointment (three sessions a week) of Mrs. M. Whinnom, B.Sc., Dip.Ed., whose time is shared between the Child Guidance Clinic and the School Psychological Service. This resulted immediately in less delay between referral and appointments, particularly in cases referred from school.

A feature of the referrals in the last year has been an increase in the number of children with impaired hearing, where there is a clear need to investigate the inter-action between intelligence, learning difficulties and sensory defects. This increase has resulted from the liaison in the audiology clinic between the

TABLE I
SUMMARY OF SURVEY OF CHILDREN BORN BETWEEN 1.9.53 AND 31.8.54
ATTENDING EXETER SCHOOLS, 1967.

(and comparison with previous years 1960—1966).

Using Heaf's Multiple Puncture Apparatus and P.P.D. Tuberculin or Mantoux Test
and P.P.D. Tuberculin.

SCHOOLS		No. of CONSENT FORMS sent out	No. Accepted all the tests	Referred to Chest Physician	Absent for Test	Actual No. given diagnostic Tuber. Test	RESULT OF Tuberculin Test		B.C.G. Vaccination		IMMEDIATE RESULT OF B.C.G. Vaccination			Ulcers 10 mms. Over	M.M.R. X-RAY.* Tuber. Pos. CASES ONLY		
							Pos.	Neg.	Inoc.	Absent	Satis.	Not satis.	Absent		Satis.	Not satis.	Absent
L.E.A.	Girls	523	463	—	5	468	76	382	(1 Neg. but consent not given for Vacc.) 351		375	1	5	—	4	—	—
	Boys	640	578	—	7	571	63	508	508	—	481	12	15	—	8	—	—
TOTAL L.E.A. SCHOOL CHILDREN		1,163	1,041 (89.5%)	—	12	1,029 (98.8%)	139 (13.5%)	890 (86.5%)	889	—	856 (1 Neg. but consent not given for Vacc.)	13	20	—	12	—	—
INDEPENDENT	Girls	172	143	—	1	142	13	129	129	—	129	—	—	—	—	—	—
	Boys	35	30	—	2	28	2	26	26	—	26	—	—	—	1	—	—
TOTAL INDEPENDENT SCHOOL CHILDREN		207	173 (83.6%)	—	3	170 (98.3%)	15 (8.8%)	155 (91.2%)	155	—	155	—	—	—	1	—	—
GRAND TOTAL, 1967		1,370	1,214 (88.6%)	—	15	1,199 (98.8%)	154 (12.8%)	1,045 (87.2%)	1,044	—	1,011 (1 Neg. but consent not given for Vacc.)	13	20	—	13	—	—
GRAND TOTAL, 1966		1,177	1,040 (88.4%)	—	19	1,021 (98.2%)	94 (9.2%)	927 (90.8%)	921	6	905	—	16	2	11	—	—
GRAND TOTAL, 1965		1,318	1,113 (84.4%)	—	37	1,076 (96.7%)	135 (12.5%)	941 (87.5%)	923	7 (3 consent for test only)	900	—	23	5	27	—	—
GRAND TOTAL, 1964		1,517	1,283 (85.3%)	—	39	1,224 (96.9%)	156 (12.7%)	1,068 (87.3%)	1,053	13	1,027	—	26	3	28	—	—
GRAND TOTAL, 1963		1,280	1,063 (83%)	2	20	1,042 (98%)	116 (11.1%)	926 (88.9%)	920	1	913	1	6	15	39	—	—
GRAND TOTAL, 1962		1,464	1,257 (85.8%)	7	47	1,203 (95%)	159 (13.2%)	1,044 (86.8%)	1,030	16	989	3	38	3	63	—	7
GRAND TOTAL, 1961		1,174	1,015 (86%)	8	33	974 (96%)	90 (9%)	884 (91%)	882	2	856	2	21	3	86	—	4
GRAND TOTAL, 1960		1,669	1,428 (85.5%)	34	36	1,358 (95%)	149 (11%)	1,209 (89%)	1,189	10	1,176	1	22	3	140	—	3

* From Autumn Term 1962 only the strongly tuberculin positive cases have been x-rayed.

regional hospital board, local authority services and the school for the deaf.

There have been changes in the remedial service, too. Mr. R. D. Pankhurst, who is now deputy head at Southbrook, has been replaced by Mr. A. Hall, whose work is divided between Beacon Heath Primary and Ladysmith Boys' Secondary Modern Schools. Other schools that now have the assistance of a remedial teacher (half time) are Bradley Rowe Junior Boys' and Junior Girls' and Alphington Primary. Since September the child guidance clinic has also had the services of a remedial teacher (half time). As a result, ten children, for whom educational retardation is an important factor in their emotional problems, now have intensive teaching for four hours a week. This has already begun to pay dividends in the emotional development of these children as well as in their educational progress.

At the beginning of the Easter term, Southbrook School opened under the headship of Mr. Kerr. The selection of these pupils involved detailed assessment of individual cases referred by head teachers, school doctors and, in a few instances, by parents, as well as surveys for the 7+, 11+ age groups over the previous two years. After consultation with head teachers and parents about the possibility of transfer, each child was medically examined by the school doctor before a final decision was taken. Exeter City children attending the residential E.S.N. schools were also reviewed by Dr. C. Baker (then a school medical officer) and myself (educational psychologist). It was possible to recall seven children to continue their education at Southbrook.

The criteria for selection of pupils began from the premise that preference must be given to those children whose learning difficulties necessitated long-term intensive help. Southbrook School, with smaller classes under teachers who particularly understood these children's problems would best serve their educational and social needs.

The attitude of parents to transfer is worthy of comment. Only in six out of over one hundred cases did parents, after a discussion of the opportunities of special education, turn down the offer of a place for their child. Prior to its opening, parents and the children were invited to the school by Mr. Kerr.

The school was full from September, 1967, forty-four of the one hundred and forty places being filled by Devon County children, the remainder being the City's allocation. This means that Southbrook caters for 0.8% of the school population. Unfortunately, despite the excellent work the school is already doing, it does not answer the City's needs in terms of special education for slow learners. Already there is a waiting list of seventy-five children who cannot obtain education appropriate to their needs without extra classrooms being provided. In many of these cases the need is indeed pressing. It would seem that we need sufficient places for approximately one and a half per cent of the school population to deal effectively with this problem.

MEDICAL EXAMINATION OF ENTRANTS TO COURSES OF TRAINING FOR TEACHING AND TO THE TEACHING PROFESSION — MINISTRY OF EDUCATION CIRCULAR 249

143 students (60 men and 83 women) and 15 teachers (9 men and 6 women) had complete medical examinations with radiographic examinations during the year in regard to their fitness for the teaching profession. All reports were satisfactory.

FURTHER EDUCATION

Exeter Technical College students attending full-time courses on domestic science, nursing, hairdressing, institution management and building are medically examined by the school doctors as soon as possible after entry to the college. 50 were examined in 1967. All reports were satisfactory.

TUITION IN HOSPITALS

The local education authority continue to provide educational facilities in the two main general hospitals in the city (Royal Devon & Exeter Hospital and the City Hospital). During the year 95 children received education whilst in-patients at these hospitals (including 33 from Exeter, 59 from Devon County and 3 from other areas). 2 Exeter and 5 Devon County children were receiving education in these hospitals on or about 18th January, 1968.

Mrs. Alan Bartlett has given tuition to 95 pupils during the past year in the Royal Devon & Exeter Hospital and the City Hospital (85 in 1966) of whom 33 were from the City of Exeter. At any one time there are about 10 children receiving tuition in each of the general hospitals. They are mostly long-stay patients, but even those on a short visit to hospital frequently express a wish to participate in both work and play. Casual visitors to a class are not registered. The hospital day is long; for many children unlimited freedom becomes unattractive after a few days, and at this point they welcome some direction to their activities.

Almost all the teaching continues to be in the form of individual work schemes at both hospitals. A small room off the children's ward at the City Hospital is provided for school purposes, and this has proved most useful both for group work and occupational activities, but in emergencies even this room may not be available. Discussions between the doctor and the teacher have proved useful.

The heads of secondary schools have kindly lent textbooks for the older pupils.

During the year a full-time teacher and a classroom were provided for the education of seriously mentally disturbed children at the children's unit, Wonford Hospital, Exeter. 14 Exeter, 20 Devon and one child from elsewhere received

education during the year. 20 children (6 Exeter, 12 Devon and 2 from other authorities) were receiving education on 18th January, 1968.

Additionally, there are hospital special schools in the Princess Elizabeth Orthopaedic Hospital and in the Angela Home staffed by the Devonian Orthopaedic Association (4 Exeter children attending as at 18.1.68) and also in Honeylands Children's Hospital staffed by this authority (4 Exeter children attending as at 18.1.68).

Home Tuition. Education Act 1944—Section 56

During the year, 10 new cases, viz. : rheumatism (2), fractures (2), duodenal ulcer (1), apendymo blastoma (1), severe asthma (1), infective hepatitis (1), contusion of heel (1), blood disease (1), and 5 cases continuing from 1966, viz. : spina bifida (1), congenital heart lesion (1), severe epilepsy (1), psychosis (1), multiple fractures (1), received home tuition arranged by the education authority. 2 were still having home tuition at the year end. The others had resumed normal schooling.

Transport

Transport to and from school was provided during the year for 37 new cases, viz. : fractures (13), partial deafness (6), knee/ or spine/foot defects (8), poliomyelitis sequelae (3), miscellaneous others (7); in addition 16 children "carried over" from 1966 continued to have transport provided during 1967 : 20 children still had it at the year end.

EPILEPTIC SCHOOL CHILDREN

We have 47 children classified as suffering from epilepsy. 41 children (19 boys and 22 girls) attend ordinary schools in the city; 4 children (2 boys and 2 girls) attend Southbrook Day School for educationally subnormal children; 1 girl attends a residential special school on account of maladjustment, and 1 boy has been excluded from school suffering from severe epileptic fits.

Three new cases (all boys) were reported during the year and 14 children had left school.

Epileptic School Children known to us

Sex	Total	AGE				EPILEPSY			Have had Hospital Investigation
		5-7	7-11	11-15	Ov'r 15	Min'r	Maj'r	Both minor and major	
Boys	24	1	15	7	1	11	13	—	24
Girls	23	—	11	11	1	8	13	2	23

PHYSICALLY HANDICAPPED CHILDREN

At the end of the year, there were 21 children classified as physically handicapped, 7 less than in 1966. We had 1 new case in 1967.

HANDICAP	SEX		AGE GROUP				EDUCATION			Able to take P.T. and Games		
	Boys	Girls	Under School Age	Inf.	Jnrs.	Snrs.	Day Special School	In Res. Special School	In Ord-inary School	Home Tuition	Nil	Mod. Full
1. Cerebral Palsy ...	4	—	—	—	1	3	1	3	—	—	3	1
2. Heart: Congenital ...	1	1	—	—	2	—	—	—	1	1	2	—
3. Poliomyelitis ..	2	1	—	—	1	2	—	—	3	—	2	1
4. Other Congenital Defects	8	4	—	1	2	9	1	4	6	1	6	3
5. Miscellaneous	—	—	—	—	—	—	—	—	—	—	—	—
TOTAL	15	6	—	1	6	14	2	7*	10	2	13	5
			21				21			21		

* Includes 2 boys and 1 girl attending hospital special schools.

Observations by Health Visitor for Handicapped Children

(Miss G. M. Bastow)

At the beginning of the year only those children who were attending special schools because of physical handicap were being visited, as and when required. In April it was agreed that all infants who were considered likely to be handicapped in a substantial way should be included on the list. By the end of the year the following number of handicapped children had been referred to me :

PRIMARY HANDICAP		Aged 0-5 Yrs.	Aged 5-18 Yrs.
Deaf or Partially Hearing	....	6 (2)	9 (2)
Blind or Partially Sighted	....	6 (3)	1
Cerebral Palsy	....	9 (3)	6 (3)
Epilepsy	....	3 (2)	3 (2)
Spina Bifida and/or Hydrocephalus	....	10 (3)	2
Autism	....	1	1 (1)
Aphasia	....	—	1 (1)
Congenital Heart Defect	....	—	2
Severely Asthmatic	....	—	3
Paralysis other than Cerebral Palsy	....	3 (1)	—
Severely Mentally Subnormal	....	5 (5)	—
TOTALS	....	43 (19)	28 (9)

Of the 71 children, 28 (as shewn in brackets) had multiple handicaps.

132 visits have been paid to these children (more in the form of social casework than of routine follow-up). This compares with 32 visits in 1966.

General Comments

An interesting development in the care of young physically handicapped children has been the increasing tendency to refer them to the Spastics' Clinic, by both the Paediatricians and the Orthopaedic Surgeons. This clinic now provides physiotherapy for a number of, but not all, the young spina bifida and/or hydrocephalic children, as well as for some other types of paralysis or weakness of limbs, and for several babies who show deviant movement patterns and are retarded in physical milestones, although there may be no definite sign of cerebral palsy. The referral of children other than those who are cerebrally palsied would seem to be geared to the anticipated opening of Vrnach House (Spastic Centre) and to the extension of Honeylands Children's Hospital.

Many visits have been made to public and voluntary organisations concerned with these children, and also with regard to the placement of pre-school physically handicapped children

in play groups. In appropriate cases, and where necessary, the Council pays fees and provides transport. On the whole, this scheme seems to be working successfully. Care has been exercised in the selection of the play group. These vary in size and organisation and severely physically handicapped children placement must be in small, orderly groups.

Parent Guidance

Deaf and Partially Hearing

This group is fairly well catered for by home visiting by the peripatetic teacher, and by the local branch of The Deaf Children's Society. However, it is hoped to start an informal regular meeting for the parents of young children who have difficulties in communicating by speech, under the guidance of the teacher of the deaf and the health visitor. This group would include autistic and aphasic children under 7 years of age as well as the deaf and partially hearing.

Blind and Partially Sighted

No special provision is made for the pre-school child in this group. It is difficult to assess the degree of handicap and the need for special help for the child and his parents. Although it is known that some of these children will eventually attend the School for the Partially Sighted unless totally blind, they are not normally registered by the ophthalmic surgeons.

Cerebral Palsied

This group is probably the best catered for of all physically handicapped children. The Spastics' Clinic provides the parents with the means of meeting together in groups while their children are receiving physiotherapy, and many social activities are arranged for both parents and children. The children are also encouraged to play together when attending for treatment. With the opening of Vranck House and the additional opportunity of schooling which this will afford many of these children, their immediate future seems adequately covered. There are, however, a number of medico-social problems arising from time to time which cannot be dealt with adequately by physiotherapist or teacher, and for this reason I have maintained regular contact with the clinic throughout the year.

Epileptics

The number of cases of severe, intractable epilepsy is small and, on the whole, these children manage to "get by" until such time as they leave school. Parent guidance is probably best undertaken on an individual basis, especially as there is always hope in the early years of bringing the fits under control. It is apparent, however, that the parents of severely epileptic children do feel very isolated with their problem and are in need of support, yet they are diffident in seeking help.

Spina Bifida and/or Hydrocephalus

There is an increasing number of children surviving with this congenital abnormality. The majority of these children are under the care of at least four consultants in different branches of medicine and surgery—i.e. paediatrician, neuro-surgeon, orthopaedic surgeon and genito-urinary surgeon. All of these specialists may require the child to be admitted to hospital from time to time for assessment and investigation, for replacement of Spitz Holter valves and tubes for bladder electrode implants or operations on the genito-urinary tract and for orthopaedic surgery. In addition most of these children attend either the Princess Elizabeth Orthopaedic Hospital or the Spastics' Clinic once, twice or three times a week for physiotherapy, and they also have frequent follow-up outpatient appointments at the various hospitals. Most of the pre-schoolchildren in this group are also attending playgroups for two sessions per week under the health committee's scheme. All this entails an exhausting amount of running about for the mothers and it is therefore unrealistic to think of yet another session for "parent guidance".

Plans for the future suggest that most, if not all of these severely physically handicapped children will be receiving their education as day pupils. This will inevitably impose considerable strain on the parents, as well as calling for a combined effort from all those concerned, in assisting the children to attain a maximum of independence at home. In some cases, practical and financial help may be required in supplying aids and gadgets to assist with bathing, toileting and dressing.

(See also Appendix II).

CHILD GUIDANCE REPORT FOR 1967

(Report by Dr. H. S. Gaussen, Medical Director)

This report, for the year 1967, is my last as Medical Director of the Exeter City (and incidentally of the East Devon) Child Guidance Clinics. The city clinic opened in October, 1947 under my medical direction, and I started working for Devon County Council soon afterwards. In 1963 the two clinics were housed in our present premises and have worked together very closely, being financed by the two authorities and the regional hospital board. Work and staff have increased and the link with the hospitals is bound to get closer. The term "child guidance" is still a useful one but the emphasis has changed over the years, and now lies on family and parental guidance. In the twenty years, it has been recognised that the psychiatric problems of the child differ from those of the adult, and that the main hope of community mental health lies in prevention and education during the formative years.

Although this is a report for the past year, I hope I may be allowed a glance at the future in the light of my experience. Those who have followed the development of social service for

children and their families will realise that there has been a great proliferation of these services and that an immense specialization has been going on. Unfortunately, children only too often have multiple handicaps, and there are deep gulfs between the various agencies. There is a very real danger that the child as a whole may be lost. The child is not a diminutive adult, and his handicaps are threats to his becoming fully grown. The mental and physical aspects of life are often considered separately, for convenience, but this is very seldom justified in childhood. A broken leg at a crucial time may retard education and alter the course of a life.

Child guidance has stood for team work, for the integration of the social, the educational and the medical aspects of work with children in difficulties. It has stood for the pooling of information about a given child in its family setting, in his school, with his particular medical problem. The psychiatric social worker, the educational psychologist and the psychiatrist all contribute, in varying proportions, and the decision is that of the team. Each member is a specialist in his or her own field, each is in touch with others of his discipline. Child guidance has come, therefore, to stand for an approach to the whole child in its environment—an environment which may itself need alteration and improvement. The members of the team learn from each other.

Child guidance stands, also, for a key position, a vital link in the social services. It serves the deprived, the delinquent, the maladjusted child. With these, other agencies are also concerned, and few children seriously at risk escape from involvement with two or three. It is part of the local authority service for children at its school and, therefore, part of the school health and welfare services.

Child guidance stands for case work with the individual child and his family. It is not only for those who have fallen by the wayside but also for those who need a far-seeing approach to some personal problem. Bereavement or a broken home may mean a crisis with grave social, educational and medical problems which only a personal relationship with workers of skill and experience can resolve. Or a gifted child may be in danger of breakdown just because of the number of choices before him.

I would like to conclude this rather personal report with thanks to the committee who has supported the clinics and to all the members of their staff who have co-operated so closely with me. The place of child guidance in the community is a unique one—I hope and trust that the value of the team approach to children's problems will always be maintained.

CHILD GUIDANCE CLINIC STATISTICAL RETURN FOR 1967

TABLE A

1.	Number of cases on the books on 31st December, 1966	93
2.	Number of cases awaiting investigation on 31st December, 1966	4
3.	Number of cases investigated but awaiting treatment on 31st December, 1966	7
4.	Number of new cases referred during 1967	167

Source of Reference :

(a)	Juvenile Court	2
(b)	Probation Officers	4
(c)	School Medical Officers	29
(d)	Hospitals	10
(e)	Other Doctors	56
(f)	Head Teachers	18
(g)	Parents	27
(h)	Others	21
5.	Number of old cases re-opened during 1967	12
6.	Number of cases investigated during 1967	142
7.	Number of cases treated for the first time during 1967	74
8.	Total number of individual children seen during 1967	272
9.	Total number of attendances during 1967	1,502
10.	Total number of cases discharged during 1967	165

Reason for Discharge :

(a)	Treatment completed (see below)	78	} 165
	Symptom free	18	
	Much Improved	37	
	Satisfactory	10	
	Improved	9	
	No change	4	
(b)	Diagnosis with advice only	48	} 27
(c)	Unsuitable for treatment	6	
(d)	Defaulted	4	
(e)	Left city	2	
(f)	Other reasons	27	
11.	Number of cases remaining on the books on 31/12/67	107	
12.	Number of cases awaiting investigation on 31/12/67	2	
13.	Number of cases investigated but awaiting treatment on 31/12/67	15	

N.B.—27 cases included in 10 above were closed whilst awaiting or before investigation was completed.

SPEECH THERAPY

(Observations by Miss I. W. Hastings, L.C.S.T.)

During 1967 there have been some changes in staff. Mrs. Cope left us, and Mrs. Rees was only able to attend for two sessions at Ellen Tinkham House (training centre). Mrs. Peel increased the number of her sessions to eight a week; in all we have the equivalent of two whole-time speech therapists (i.e. less than establishment by 8 sessions a week). The waiting list at the end of the year numbered 90.

The idea of a speech centre adjacent to the new Audiology Clinic has been accepted in principle. There is already good co-operation between us and the assessment clinics have proved of great interest and value. One weekly session is being started at Southbrook School for educationally subnormal children.

Mrs. Peel reports that at Buddle Lane Clinic most of her work has been with the children who have difficulty in producing specific sounds correctly; some of these children also lisp. Mrs. Peel also reports a great improvement in the response of parents who are offered initial appointments, and better co-operation in the home generally.

The clinic for cleft palate cases held at the City Hospital once a month is a very useful and interesting one—it is a combined clinic of a paediatrician, a dental surgeon, an orthodontist and speech therapists (both County and City). Mr. Selley, the dental surgeon, has, for about ten years now, been fitting little plates into the mouths of these cleft palate babies on the day they are born, if possible, and always by the third day. This means that the baby can be breast fed or bottle fed without regurgitation, and so thrives. Also, with the gap filled by the plate, breathing will be through the nose, and this means that there is less chance of the baby developing chest troubles. This plate provides the correct stimulus to the tongue, and helps to hold and pull into position the section or sections of the jaw which have failed to unite before birth, so that when the time comes for plastic surgery, operative treatment is more successful, as the gaps are lessened and the alignment of the jaw is corrected as far as possible before the operation.

As the time for operative treatment draws near, blood tests and swabs are taken and any necessary action taken, so that the child goes to the hospital fit and ready—and does not have a longer stay away from home and parents than is absolutely necessary. If the lip is cleft on both sides, and the pre-maxilla is protruding and being pulled up or sideways by the nose, the mother is taught how to manage this by first putting a piece of sellotape on each of the baby's cheeks, and then using across the lip a strip of elastoplast doubled over, which is secured by sticking the free ends of the elastoplast to the sellotape instead of directly on to the baby's face. It can be changed as often as necessary, and is removed during feeding.

This gives sufficient pressure to keep the pre-maxilla in place, and the mother is involved in helping her child from the

very beginning. The parents are shown photographs of other babies treated in this way "before" and "after" treatment, and the results are usually extremely satisfying to all concerned. When the lip is repaired there is only a very small gap to close, and the teeth have a good chance of coming down into more normal alignment. The whole result is a better mouth altogether for the production of speech.

The parents meet early on the therapist who will treat the child, so that when treatment begins at the clinic the child does not have to face a stranger.

A small group of these little ones (of two and three years of age) attend the Whipton Clinic. Treatment with such a group is organised through play and the chatter which accompanies play—the correct speech patterns being insisted upon as far as possible; in this way an awareness of correct sounds in a pleasant and enjoyable atmosphere is aroused. The mothers are present during the treatment and this gives them the opportunity of hearing their child produce better speech, so that they know what standard to expect in the home. It also gives them a chance to meet each other, and to discuss their experiences and problems with each other, as well as with the therapist.

STATISTICS

Analysis of the cases treated during the year

DEFECT	Having treatment 1.1.67	TABLE A DISCHARGED				STILL ON LIST				Remaining 31-12-67
		Admitted during 1967	Total	Cured	Other	Under observation	Regular Attendance	Improved	No change	
Stammering	48	13	61	4	12	19	26	42	3	45
Simple Dyslalia	4	5	9	3	—	3	3	6	—	6
Multiple Dyslalia	74	25	99	9	19	19	52	64	7	71
General Dyslalia	29	14	43	8	6	11	18	27	2	29
Language Defects	13	16	29	3	1	4	21	18	7	25
Dysarthria	26	17	43	22	3	6	12	18	—	18
Cleft Palate	5	6	11	—	—	2	1	8	—	9
Hyper-rhinophonia	—	—	—	—	—	—	—	—	—	—
Alalia	6	1	7	1	2	2	2	4	—	4
Sigmatism	23	2	25	2	6	5	12	17	—	17
TOTALS	228	99	327	52	51	70	154	205	19	224

In Dyslalia the child cannot produce the correct sound and therefore substitutes one sound for another; in Dysarthria there is difficulty in articulation; in Hyper-rhinophonia the speech is excessively nasal; Alalia is the complete lack of intelligible speech; Sigmatism is lisping.

DEFECT	Remain ing on 31.12.67	PRE-SCHOOL		TABLE B				SENIOR		JUNIOR TRAINING CENTRE	
				INFANTS		JUNIOR					
		Boys	Girls	Boys	Girls	Boys	Girls	Boys	Girls	Boys	Girls
Stammering	45	3	—	6	2	15	2	12	5	—	—
Simple Dyslalia ...	6	1	—	1	1	2	1	—	—	—	—
Multiple Dyslalia ...	71	6	4	14	7	30	4	5	1	—	—
General Dyslalia ...	29	1	1	9	4	4	6	2	2	—	—
Language Defects ...	25	8	5	—	—	1	—	—	—	5	6
Dysarthria ...	18	6	2	4	1	3	—	—	1	1	—
Cleft Palate ...	9	3	1	1	—	2	—	—	1	1	—
Hyper-rhinophonia ...	—	—	—	—	—	—	—	—	—	—	—
Alalia ...	4	—	—	1	—	1	1	—	—	—	1
Sigmatism ...	17	—	—	1	2	8	2	1	3	—	—
TOTALS	224	28	13	37	17	66	16	20	13	7	7

TUBERCULOSIS

(Report kindly submitted by Dr. G. E. Adkins, Chest Physician,
in the absence of Dr. R. P. Boyd)

Register

The number of school children on the tuberculosis register shows an overall decrease of 8—viz. : 5 respiratory and 3 non-respiratory.

New Notifications

There were two new notifications (brothers), both respiratory and contacts of a known case.

Deaths

There were no deaths of school children from tuberculosis during the year.

Contact Tracing

No new cases were found among the contacts of the boy notified late last year.

The two notifications this year were not received until the last week in December and contact tracing will be effected early in 1968.

Tuberculin Testing Survey

As a result of Heaf testing, 13 children were found to be strongly positive and referred to the Chest Clinic for follow up procedure. One was not a resident in Exeter. 6 were noted for recall, 6 were discharged not to be seen again and the remaining child did not attend as he is a known contact and attending the Chest Clinic as such.

None of the children was suffering from respiratory tuberculosis.

TUBERCULOSIS

**School Children (5-15 years of age) suffering from Tuberculosis
whether in Maintained or Independent Schools.**

On Register as at 1st January, 1967.

	Respira- tory		Bones & Joints		Cervical Glands		Meninges		Others		Total	
	B.	G.	B.	G.	B.	G.	B.	G.	B.	G.	B.	G.
Children attending main- tained primary and sec- ondary schools	7	7	—	—	1	—	—	—	—	—	8	7
Attending special schools	—	1	—	—	—	—	—	—	—	—	—	1
Attending independent schools	—	2	—	1	1	1	1	—	—	—	2	4
TOTALS	7	10	—	1	2	1	1	—	—	—	10	12

Changes during 1967

	Respiratory		Bones & Joints		Cervical Glands		Meninges		Others		Total	
	B.	G.	B.	G.	B.	G.	B.	G.	B.	G.	B.	G.
New notifications during 1967	2	—	—	—	—	—	—	—	—	—	2	—
Inward transfer	—	—	—	—	—	—	—	—	—	—	—	—
Notified children reaching school age during the year	—	3	—	—	—	—	—	—	—	—	—	3
TOTALS	2	3	—	—	—	—	—	—	—	—	2	3
Cases leaving school during the year	—	1	—	—	1	—	—	—	—	—	1	1
Outward transfer	1	—	—	—	—	—	1	—	—	—	2	—
Cases removed from register 'recovered'	4	4	—	1	—	—	—	—	—	—	4	5
TOTALS	5	5	—	1	1	—	1	—	—	—	7	6

On Register at 31st December, 1967.

	Respiratory		Bones & Joints		Cervical Glands		Meninges		Others		Total	
	B.	G.	B.	G.	B.	G.	B.	G.	B.	G.	B.	G.
Children attending maintained primary and secondary schools	2	7	—	—	1	—	—	—	—	—	3	7
Attending special schools	—	1	—	—	—	—	—	—	—	—	—	1
Attending independent schools	2	—	—	—	—	1	—	—	—	—	2	1
TOTALS	4	8	—	—	1	1	—	—	—	—	5	9

1967 B.C.G. VACCINATION

MINISTRY OF HEALTH CIRCULARS 22/53, 7/59, 6/61 and 19/64

Parental consent for the test was received for 1,214 (88.6%) of the 1,370 thirteen-year-old children in maintained and independent schools in the city. 1,199 (98.8%) were given a tuberculin test and 15 were absent on three occasions when the tests were given. Of the 1,199 tested, 154 (12.8%) were tuberculin positive (this percentage has been fairly stable over the past 14 years and is not declining); of the 1,045 who were negative, 1,044 were given B.C.G. vaccination, using freeze-dried vaccine. Parental consent for B.C.G. vaccination was not given for one child.

13 strongly tuberculin-positive children were chest x-rayed by the mass miniature radiography unit and all were found to be satisfactory.

It has been noted that reaction to B.C.G. vaccination since freeze dried vaccine has been used seems to be much less marked than when fresh vaccine was used. During 1966 the children attending three schools, who had been vaccinated in 1965, were tuberculin tested and it was found that 23% were tuberculin negative. This year the children attending three other schools,

who had been vaccinated during 1966, were tested and a more satisfactory result of 8.8% tuberculin negative was found (see table II).

The following tables set out the details of the tests, etc. :

TABLE II
CHILDREN SKIN TESTED WHO WERE GIVEN B.C.G.
1966 AND TUBERCULIN TESTED 1967

SCHOOL	No. given B.C.G. 1966	No. Accepted Test at School 1967	No. given Heaf Test 1967	No. Positive	No. Negative
Episcopal Boys' S.M.	34	28	27	19 (70.4%)	8 (29.6%)
Episcopal Girls' S.M.	28	24	23	17 (73.9%)	6 (26.1%)
St. James Girls' S.M.	62	55	55	54 (98.2%)	1 (1.8%)
St. Thomas Girls' S.M.	84	76	76	75 (98.7%)	1 (1.3%)
TOTAL	208	183	181	165 (91.2%)	16 (8.8%)

POLIOMYELITIS VACCINATION 1967

Vaccination against poliomyelitis with oral vaccine was continued and during the year 89 children of school age (i.e. born before 1962 and under 16 years of age—as recorded in the return to the Ministry of Health) completed a course of three doses of poliomyelitis vaccine; these are not necessarily all attending local authority schools.

Fourth (booster) doses were given to 1,223 children between the ages of 5 and 12 years in the city.

T.A.B. VACCINATION (AGAINST TYPHOID AND PARATYPHOID FEVERS)

It has for some years been recognised that a considerable proportion of cases of typhoid and paratyphoid in this country has occurred in holidaymakers recently returned from abroad.

As in previous years, T.A.B. immunisation was offered, subject to parental consent, to parties of school children attending the council's maintained schools, who were going abroad on educational visits.

In the three schools concerned, 91 children were given protection.

DIPHTHERIA (Booster) AND TETANUS IMMUNISATION IN SCHOOLS

Offers were made of immunisation, to all 10-year-olds in school as under :

<i>Children who in infancy :</i>	<i>Offered.</i>
1. Had had Diphtheria/Tetanus immunisation.	Booster dose Diphtheria/Tetanus prophylactic
2. Had had Diphtheria immunisation only.	Booster dose Diphtheria prophylactic with full course Tetanus prophylactic
3. Had not had either Diphtheria or Tetanus immunisation.	Full course Diphtheria/Tetanus prophylactic

In all 1,041 doses of tetanus prophylactic and 654 doses of diphtheria prophylactic were given to 963 children in school aged 10 years whose parents took advantage of the offer. This includes 234 children who commenced a primary course of tetanus protection in 1966 and completed it in 1967.

INFECTIOUS DISEASES

Incidence of certain infectious diseases other than tuberculosis in 1967 in children (Exeter residents) 5-15 years of age.

(Corrected for change of diagnosis)

DISEASE	Boys	Girls
Scarlet Fever	14	25
Whooping Cough	2	3
Measles	141	148
Pneumonia	—	1
Dysentery	14	11
Food Poisoning	3	3
Poliomyelitis (Paralytic) (Non-Paralytic)	—	—
Meningococcal Infection	—	—
Diphtheria	—	—
Erysipelas	—	—
*Gastro-Enteritis	1	3

* Not notifiable : cases are known to the department by informal notification.

**SMALLPOX VACCINATION
VACCINATION STATE AS NOTED DURING SCHOOL
ENTRANTS' MEDICAL EXAMINATIONS IN 1967.**

Year of Birth	Vaccinated	Not Vaccinated	Not Known	TOTAL
1963 and later	31	9	6	46
1962	345	106	135	586
1961	480	128	108	716
GRAND TOTAL	856	243	249	1,348

Vaccination is recorded by the school nurses from information given to them by the parents. 63.5% of the school entrants examined by complete periodic medical examinations during the year were *stated* to have been vaccinated.

Scabies

Only one case was reported during the year ; in some parts of the country there has been a recrudescence of scabies, which is due to a mite burrowing into the skin.

HOSPITAL REPORTS

During the year 1,084 reports were received from local hospital consultants (949 from the Royal Devon and Exeter Hospital, 135 from the Princess Elizabeth Orthopaedic Hospital) about children referred to them through the school medical officers or direct by the child's own doctor ; these reports are much appreciated.

DEATHS

I am sorry to have to report 3 deaths : acute lymphatic leukaemia (1), a boy aged 13 ; severe burns following a fire at her home (1), a girl aged 8 years ; and following a road accident (1), a girl aged 15 years.

SCHOOL MEALS AND MILK REPORT, 1967

I am indebted to the Director of Education and the School Meals Organiser for this information.

During the year there has been an increase in the number of children taking meals. The statistical return required by the Department of Education and Science, shown below, indicates the number of children taking milk and meals on selected dates during the last three years.

MILK			MEALS		
DATE	Number of Children taking Milk	Percentage	Number of children taking Paid Meals	Number of children taking Free Meals	Percentage
22.9.67	9,775	82.8	6,784	751	63.9
22.9.66	9,572	82.1	6,315	650	59.8
23.9.65	9,031	85.69	6,265	605	55.61

During the major holidays, meals were provided for necessitous children at three centres. The attendance was as follows :—

HOLIDAY	Number on register for free meals	Average daily attendance	Percentage of attendance of those eligible
Easter	970	334	31.43
Summer	957	256	26.75
Christmas ...	990	266	26.86

The increase in the number of free meals was due to the Department of Education and Science amending the income scale for the provision of free meals from the beginning of the Spring Term.

The charge for the meals remained at 1s. 0d. Free meals were granted according to parental income.

In April a kitchen was opened at the new Southbrook School.

Self-contained canteens operated at 17 schools. St. David's School is now served by Montgomery Kitchen and a kitchen has been provided in the new Southbrook day school for Educationally Sub-Normal children ; otherwise the arrangements are as set out in the report for 1966.

Kitchen	Number of Meals		Kitchen	Number of Meals	
	Recognised capacity	Average daily output		Recognised capacity	Average daily output
Montgomery	1,000	1,231	Bradley Rowe	750	783
Ladysmith Boys' S.M.	350	626	Summerway J.M. & I.	375	671
Priory Girls' S.M.	375	312	Vincent Thompson Boys' S.M.	375	401
Countess Wear J.M.	375	335	Whipton Infants'	375	479
Hele's School	375	272	Hele's Annexe	375	329
Bishop Blackall	375	398	Chestnut Av. Nursery	40	39
Stoke Hill J.M.	200	280	Beacon Heath J.M. & I.	200	366
St. James' Girls' S.M.	250	238	St. Thomas Girls' S.M.	200	287
Alphington J.M. & I.	150	122	Topsham	750	291
Pinhoe Infants'	250	243	Southbrook School	150	89

Kitchen supervisors are co-operative in supplying special diets where necessary. During the year the number of children on special diets rose to 37, the majority of whom were on reducing diets.

HEALTH EDUCATION

(Health Education Officer, Miss E. H. Robertson,
S.R.N., S.C.M., R.N.T.)

Health Education courses concerned with various aspects of personal hygiene, nutrition and home safety have been given to 11-year-old pupils in secondary modern schools as below. (Films, transparencies, flannelgraphs and other visual aids have been used) :

Priory School	....	four courses of 12 lessons.
St. Thomas School	....	three courses of 12 lessons.
Episcopal School	....	three courses of 12 lessons.
St. James School	....	two courses of 12 lessons.

Modified courses have also been given at :

St. Loyes College (Junior Training School), and
Southbrook Day Special School for Educationally Sub-normal children and the Exeter Technical College, where talks concerning drugs and drug addiction were also included.

Parentcraft courses have been given to pupils in their last year at :

The Priory, Episcopal, St. James and St. Thomas Girls' Secondary Modern Schools. At the last school, in conjunction with John Stocker Boys' Secondary Modern School, one course was arranged for boys and girls together, as part of the experimental co-educational "raising-school-leaving-age course".

Resuscitation

Classes were arranged for pupils at the Episcopal School taking the Royal Life Saving Society's Certificate in the Holger Nielson and mouth to mouth methods of resuscitation and external cardiac massage.

Health Education Teaching Aids

Posters, leaflets, films, film strips, etc. have been supplied to schools as part of relevant health education programmes and in response to requests from teaching staff. Teaching aids have also been supplied to student teachers from St. Luke's College engaged in Health Education projects.

Smoking and health campaigns form an integral part of the school health education programme, use being made of current poster, the "Smoking Machine" film, produced by the Ministry of Health and the Department of Education and Science, and the "fashionable non-smoker flannelgraph". The health education officer reports that while most eleven-year-old children have experimented with smoking the majority of older girls do not seem interested, except for a few who smoke occasionally because their friends do.

SCHOOL ACCIDENTS

(Observations by Dr. G. P. McLauchlan)

170 accidents to children in school (104 boys ; 66 girls) have been reported this year (last year 147). This represents approximately 13 accidents for every 1,000 children attending the city's schools.

A. Secondary Schools

88 accidents (49 boys ; 39 girls) were reported in secondary schools representing 18 accidents for 1,000 children.

Place of Accident	Number of Accidents		(Brackets shew figures in 1966)
During physical exercises		28 (23)	When not using apparatus 7 While using apparatus 21 (box or buck 8, trampoline 4, trampette 2, trapeze 2, bench 1, ropes 1, high bar 1, parallel bars 1, climbing frame 1)
In playground during free play		19 (25)	
During organised games		16 (14)	Netball 7, Athletics 6, Football 1, Rugby 1, Cricket 1.
In classroom		15 (10)	Chemistry 4, Domestic Science 3, General 3, Woodwork 1, Biology 1, Art 1, Crafts 1, Dancing 1.
In passage to and from class		8 (14)	
At swimming baths		2 (—)	

B. Junior Schools

There were 55 accidents (37 boys ; 18 girls) reported by junior schools representing 12 per 1,000 children.

Place of Accident	Number of Accidents		
In playground during free play		22 (38)	
During organised games		9 (—)	Football 6, Athletics 3.
In passage to and from class		8 (—)	
During physical exercise		8 (5)	While using apparatus 7 (bar 3, climbing frame 2, trampette 1, sloping plank 1). When not using apparatus 1
In classroom		6 (7)	
At swimming baths		1 (1)	
During school outing		1 (—)	

C. Infant Schools

There were 27 accidents (18 boys ; 9 girls) reported by infant schools representing 9 per 1,000 children.

Place of Accident	Number of Accidents	
In playground during free play	11	(7)
Classroom	8	(3)
During passage to and from class	4	(—)
During physical exercises	4	(—)
		While using apparatus 4 (climbing frame 2, sloping plank 1, low bar 1).

D. All Schools

Injuries Sustained	Number of Accidents	
Wounds	67	(58)
Fractures	53	(42)
Bruising	23	(17)
Sprains	12	(15)
Eye Injury	5	(1)
Scald or burn	4	(3)
Dislocations	3	(2)
Concussion	2	(8)
Tooth injury	1	(—)

Mechanism of Accidents

Fall on level	50	(43)
Fall from height	46	(41)
Hit by flying object	16	(21)
Collision with other child	15	(15)
Collision with object or structure	14	(18)
Hit by sharp instrument	11	(—)
Crushes	8	(6)
Others	7	(7)
Chemical injury	3	(—)

Accidents according to term :

Spring Term	54	(51)
Summer Term	54	(42)
Autumn Term	62	(54)

Discussion

There were rather more accidents this year than last, but it only represents an increase from 12 to 13 accidents per 1,000 children. The largest increase is shown in accidents in infant schools, but their number is still small.

Organised games and physical exercises account for half the accidents in senior schools and a third of those in junior schools. As in previous years, lack of skill and in some cases bad luck was the cause of these accidents. In no cases was there any defect

in the apparatus used. Netball, athletics and football accounted for most of the accidents during organised games and as would be expected in physical exercise most of the accidents occurred when apparatus was used.

In none of the accidents did a defect of structure play a part, though in some cases awkward stairs or walls in inconvenient places increased the hazard of play.

The 3 accidents at the public swimming baths were all the result of a child slipping round the edge of the bath. A material that will not become slippery when wet should be used for the surrounds of swimming baths.

Falls both on the level and from a height are the commonest mechanism of school accidents. Collision between children or with object or structure are a type of accident common during free play with children moving around the playground often at speed.

Fractures always appear as a very common result of school accidents, with only wounds accounting for more injuries. It must be remembered that all accidents in school do not come to the notice of the headteacher, especially those when the injury has been minor, and so the more serious injuries tend to be prominent. There were 5 eye injuries this year, 3 due to splashing of chemicals into the eye and the other 2 due to blows. In none of them was the injury serious and no permanent injury was done to the eye.

JUVENILE DELINQUENCY

121 children (94 boys ; 27 girls) attending schools maintained by the Exeter Education Committee appeared before the Juvenile Court during 1967. Of these, 3 children (2 boys ; 1 girl) were sent to approved schools.

JUVENILES BROUGHT TO COURT			
YEAR	BOYS	GIRLS	TOTAL
1962	155	13	173
1963	141	5	146
1964	89	24	113
1965	121	17	138
1966	78	17	95
1967	94	27	121

4 boys appeared more than once before the Juvenile Court for the same kind of offence. 3 boys and 1 girl appeared more than once for different offences.

The table below sets out the sex, age group and offences committed :

Juvenile Court Cases

OFFENCES PROVED	Boys				Girls			
	AGE GROUP			Total	AGE GROUP			Total
	8-10	11-14	Over 14		8-10	11-14	Over 14	
Larceny	—	27	15	42	—	22	1	23
Larceny and Breaking In	—	2	2	4	—	—	1	1
Receiving	—	2	2	4	—	—	—	—
Wilful and Malicious Damage....	—	14	4	18	—	—	—	—
Act of Annoyance	—	—	—	—	—	—	—	—
Breach of Probation Order	—	—	—	—	—	—	1	1
Car and Motor Cycle Offences	—	—	12	12	—	—	—	—
Cycling Offences	—	3	3	6	—	—	—	—
Failing to Attend School	—	4	1	5	—	1	—	1
Being in Need of Care and Protection	2	1	—	3	—	1	—	1
Beyond Control....	—	—	—	—	—	—	—	—
TOTAL	2	53	39	94	—	24	2	27

Approved School Admissions.

During 1967, 3 children (2 boys ; 1 girl ; 1 boy was aged 15 years, the other 14 years ; the girl was aged 16 years) were sent by the Court to approved schools ;

The reasons were :

Beyond control and failing to attend school	1
Failed to comply with probation order	1
Larceny	1
TOTAL	3

PART-TIME EMPLOYMENT OF SCHOOL CHILDREN

Where a child has had a complete medical examination within the previous 12 months and subject to written confirmation by the parents that the child has had no serious illness or accident since that date, an employment certificate is issued without carrying out any medical examination.

New Cases

During the year 297 children (156 boys ; 141 girls) applied in accordance with the Bye-laws (1949) for part-time employment certificates, for the first time ; licences were issued after medical examination, to 187 children including 7 from independent schools ; 1 girl was refused a certificate of fitness because of anaemia ; 109 children were issued with certificates for employment without further medical examination.

Children Reviewed

201 children (129 boys ; 72 girls) were reviewed after working between 3-6 months. 13 of these children were medically examined but the remaining 188 were certified on their history fit to continue employment without having another medical examination ; 1 girl had her certificate withdrawn because of urinary infection.

TYPE OF EMPLOYMENT (NEW CASES)					Boys	Girls
Delivery of newspapers	....	....	....	....	132	78
Delivery of groceries	....	....	....	....	4	—
Delivery of meat	....	....	....	....	5	—
Delivery of milk	....	....	..	....	7	—
Hairdressing	....	....	...	....	—	16
Shop assistants	....	....	....	....	—	37
Waitress	....	....	....	....	—	6
Chemist	....	....	....	....	1	—
Miscellaneous	....	...	....	....	7	3
TOTAL					156	140

296

SCHOOL LEAVING REPORTS

During 1967, 37 reports were sent to family doctors about children leaving school who were handicapped or had defects or any important medical history.

79 school leaving children were reported to the Youth Employment Officer regarding suitable employments.

EMPLOYMENT OF SCHOOL LEAVERS WITH HANDICAP Reported on Form Y.9 during 1967

Form Y.9 is a medical report sent to the Youth Employment Officer indicating the employment(s) considered unsuited to the individual leaver having regard to his handicap as stated and when the handicap is such that registration under the Disabled Persons (Employment) Act, 1944 is not considered necessary.

MAIN DEFECT	Boys	Girls	Total
(a) Defective Colour Vision	37	—	37
(b) Educationally Subnormal	4	3	7
(c) Epilepsy	5	2	7
(d) Eczema	1	—	1
(e) Mild Spastic	1	1	2
(f) Hearing Defect	4	2	6
(g) Maladjusted	—	1	1
(h) Diabetic	1	1	2
(i) Defective Vision	1	—	1
(j) Heart Condition	—	1	1
TOTAL	54	11	65

Reported on Form Y.10 during 1967

(Form Y.10 is a medical report indicating severe handicaps where registration under the Disabled Persons (Employment) Act, 1944 should be considered).

MAIN DEFECT	Boys	Girls	Total
(a) Educationally Subnormal	3	5	8
(b) Deaf	3	—	3
(c) Physical Disability	2	1	3
TOTAL	8	6	14

In addition school doctors have sent memoranda to the Youth Employment Officer in respect of 12 children ; 4 epilepsy, 3 asthma and 5 miscellaneous.

During the year consideration was given to circular 9/66 of the Department of Education and Science recommending further co-ordination in regard to handicapped children (see also Appendix II).

Financial Year ended 31st March, 1967

(The City Treasurer has kindly supplied me with the following figures) :

(a)	Total cost of School Medical and Dental Services	....	....	£49,421
(b)	Cost in terms of penny rate	....	....	2.28d.
(c)	Cost per child to the Exeter Education Committee (based on a school population of 11,454)	....	....	£4.6.3d.

RETURNS TO THE DEPARTMENT OF EDUCATION AND SCIENCE

MEDICAL INSPECTION AND TREATMENT

Return for the Year ended 31st December, 1967

Number of pupils on registers of maintained primary, secondary, special and nursery schools in January, 1968 :

(i)	Form 7 Schools	....	....	12,652
(ii)	Form 7M	....	....	144
(iii)	Form 11 Schools	....	....	45
TOTAL				12,841

PART I.

Medical Inspection of Pupils attending Maintained Primary and Secondary Schools (including Nursery and Special Schools)

TABLE A—PERIODIC MEDICAL INSPECTIONS

AGE GROUPS INSPECTED (By year of birth)	No. of Pupils who have received a full medical examination	PHYSICAL CONDITION OF PUPILS INSPECTED		No. of Pupils found not to warrant a medical examination
		Satisfactory	Unsatisfactory	
(1)	(2)	Number	Number	(5)
1963 and later	46	46	—	—
1962	586	586	—	—
1961	716	716	—	3
1960	—	—	—	2
1959	—	—	—	15
1958	—	—	—	22
1957	—	—	—	22
1956	—	—	—	8
1955	—	—	—	1
1954	264	264	—	2
1953	187	187	—	2
1952 and earlier	49	49	—	20
TOTAL	1,848	1,848	—	97

TABLE A—PERIODIC MEDICAL INSPECTIONS

—continued

AGE GROUPS INSPECTED (By year of birth)	PUPILS FOUND TO REQUIRE TREATMENT (excluding dental disease and infestation with vermin)		
	For defective vision (excluding squint)	For any other condition recorded at Part II	Total individual pupils
(1)	(6)	(7)	(8)
1963 and later	1	4	5
1962	11	81	73
1961	17	104	95
1960	—	—	—
1959	—	—	—
1958	—	—	—
1957	—	—	—
1956	—	—	—
1955	—	—	—
1954	23	16	37
1953	17	23	34
1952 and earlier	4	9	13
TOTAL	73	237	257

TABLE B—OTHER INSPECTIONS

Number of special inspections	....	....	1,212
Number of re-inspections	....	....	4,062
TOTAL	....	....	<u>5,274</u>

TABLE C—INFESTATION WITH VERMIN

NOTES : All cases of infestation, however slight, should be included in Table C.

The numbers recorded at (b), (c) and (d) should relate to individual pupils, and not to instances of infestation.

(a)	Total number of individual examinations of pupils in schools by school nurses or other authorised persons	....	....	....	8,371
(b)	Total number of individual pupils found to be infested	....	....	....	85
(c)	Number of individual pupils in respect of whom cleansing notices were issued (Section 54(2), Education Act, 1944)	....	....	....	Nil.
(d)	Number of individual pupils in respect of whom cleansing orders were issued (Section 54(3), Education Act, 1944)	....	....	....	Nil

PART II.

Defects found by Periodic and Special Medical Inspections during the Year

TABLE A—PERIODIC INSPECTIONS

Defect Code No.	DEFECT OR DISEASE	PERIODIC INSPECTIONS								SPEC. INSP.	
		Entrants		Leavers		Others		Total		T.	O.
		T.	O.	T.	O.	T.	O.	T.	O.		
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)
4	Skin	19	22			5	9	24	31	8	10
5	Eyes: (a) Vision	29	128			44	33	73	161	73	64
	(b) Squint	21	14			5	1	26	15	6	1
	(c) Other	4	7			3	3	7	10	1	—
6	Ears: (a) Hearing	10	92			2	8	12	100	17	32
	(b) Otitis Media	17	58			2	2	19	60	3	6
	(c) Other	8	18			3	1	11	19	8	7
7	Nose and Throat	9	150			2	11	11	161	9	29
8	Speech	17	39			1	—	18	39	13	8
9	Lymphatic Glands	4	18			—	2	4	20	—	1
10	Heart	—	34			—	2	—	36	2	6
11	Lungs	6	47			2	5	8	52	10	15
12	Developmental:										
	(a) Hernia	1	5			1	—	2	5	1	3
	(b) Other	7	11			3	1	10	12	3	2
13	Orthopaedic:										
	(a) Posture	6	13			1	8	7	21	4	13
	(b) Feet	16	43			9	7	25	50	12	14
	(c) Other	21	26			7	3	28	29	9	11
14	Nervous System:										
	(a) Epilepsy	5	5			—	2	5	7	6	2
	(b) Other	7	9			—	2	7	11	2	6
15	Psychological:										
	(a) Development	—	17			—	2	—	19	3	13
	(b) Stability	1	27			—	2	1	29	6	11
16	Abdomen	9	6			—	2	9	8	4	6
17	Other	1	77			—	3	1	80	17	36

T means requiring Treatment.

O means requiring Observation.

PART III.

Treatment of Pupils attending Maintained Primary and Secondary
Schools (including Nursery and Special Schools)TABLE A—EYE DISEASES, DEFECTIVE VISION
AND SQUINT

	Number of cases known to have been dealt with
External and other, excluding errors of refraction and squint	96
Errors of refraction (including squint)	515
TOTAL	611
Number of pupils for whom spectacles were prescribed	329

TABLE B—DISEASES AND DEFECTS OF EAR,
NOSE AND THROAT

	Number of cases known to have been dealt with
Received operative treatment—	
(a) for diseases of the ear	25
(b) for adenoids and chronic tonsillitis	185
(c) for other nose and throat conditions	6
Received other forms of treatment	395
TOTAL	611
Total number of pupils still on the register of schools at 31st December, 1967, known to have been provided with hearing aids :	
(a) during the calendar year 1967	4
(b) in previous years	32

TABLE C—ORTHOPAEDIC AND POSTURAL DEFECTS

	Number of cases known to have been treated
(a) Pupils treated at clinics or out-patients departments	48
(b) Pupils treated at school for postural defects	21
TOTAL	69

TABLE D—DISEASES OF THE SKIN
(excluding uncleanliness, for which see Table C of Part I)

	Number of cases known to have been treated
Ringworm : (i) Scalp	—
(ii) Body ...	1
Scabies	1
Impetigo	27
Other skin diseases	241
TOTAL	270

TABLE E—CHILD GUIDANCE TREATMENT

	Number of cases known to have been treated
Pupils treated at Child Guidance Clinics	272

TABLE F—SPEECH THERAPY

	Number of cases known to have been treated
Pupils treated by speech therapists	327

TABLE G—OTHER TREATMENT GIVEN

	Number of cases known to have been treated
(a) Pupils with minor ailments	462
(b) Pupils who received convalescent treatment under School Health Service arrangements	—
(c) Pupils who received B.C.G. vaccination	1,044
(d) Other than (a), (b) and (c) above. Please specify:	
Heart conditions (incl. Rheumatism and Chorea)	12
Lungs (incl. Tuberculosis and Non-Tuberculosis conditions, Bronchitis, etc.)	138
Epilepsy and other nervous conditions	26
Miscellaneous : Glands, Abdomen, Appendicitis, Fractures, Urinary Conditions, etc.	375
TOTAL (a) — (d)	2,057

PART IV.
DENTAL INSPECTION AND TREATMENT
CARRIED OUT BY THE AUTHORITY

	<i>Ages</i> 5 to 9	<i>Ages</i> 10 to 14	<i>Ages</i> 15 & over	<i>Total</i>
First visit	1,491	1,521	345	3,357
Subsequent visits	1,772	2,803	750	5,325
Total visits	3,263	4,324	1,095	8,682
Additional courses of treatment commenced	449	352	76	877
Fillings in permanent teeth	573	2,367	747	3,687
Fillings in deciduous teeth	236	21	—	257
Permanent teeth filled	493	2,117	679	3,289
Deciduous teeth filled	211	21	—	232
Permanent teeth extracted	94	500	139	733
Deciduous teeth extracted	1,869	451	—	2,320
General anaesthetics	918	512	78	1,508
Emergencies	391	191	50	632
Number of pupils x-rayed .....	....	....	....	106
Prophylaxis .....	....	....	....	790
Teeth otherwise conserved .....	....	....	....	3,143
Number of teeth root filled .....	....	....	....	6
Inlays .....	....	....	....	NIL
Crowns .....	....	....	....	2
Courses of treatment completed .....	....	....	....	3,952
Orthodontics				
Cases remaining from previous year .....	....	....	....	245
New cases commenced during year .....	....	....	....	12
Cases completed during year .....	....	....	....	55
Cases discontinued during year .....	....	....	....	21
Number of removable appliances fitted .....	....	....	....	24
Number of fixed appliances fitted .....	....	....	....	NIL
Pupils referred to Hospital Consultant .....	....	....	....	10
	5 to 9	10 to 14	15 & over	Total
Prosthetics				
Pupils supplied with F.U. or F.L. (first time)	NIL	NIL	NIL	NIL
Pupils supplied with other dentures (first time)	NIL	13	4	17
Number of dentures supplied	NIL	17	13	30
Anaesthetics				
General anaesthetics administered by Dental Officers .....	....	....	....	780
Inspections				
(a) First inspection at school—Number of pupils .....	....	....	....	11,482
(b) First inspection at clinic—Number of pupils .....	....	....	....	1,331
Number of (a) + (b) found to require treatment .....	....	....	....	6,711
Number of (a) + (b) offered treatment .....	....	....	....	6,257
(c) Pupils re-inspected at school or clinic .....	....	....	....	657
Number of (c) found to require treatment .....	....	....	....	530
Sessions				
Sessions devoted to treatment .....	....	....	....	1,517
Sessions devoted to inspection .....	....	....	....	83
Sessions devoted to Dental Health Education .....	....	....	....	NIL

SCREENING TESTS OF VISION AND HEARING

(Where boxes are provided for the answers please place ticks in the appropriate box or enter the ages, where requested, in Arabic numerals).

- 1 (a) Is the vision of entrants tested as a routine within their first year at school?

YES	NO
✓	

- (b) If not, at what age is the first routine test carried out?

- 2 At what age(s) is vision testing repeated during a child's school life?

6	7	8	9	10	11	12	13	14	15	16
	✓			✓		✓	✓	✓		✓

- 3 (a) Is colour vision testing undertaken?

YES	NO
✓	

- (b) If so, at what age? 10 years.

- (c) Are both boys and girls tested?

BOYS	GIRLS
✓	—

- 4 (a) By whom is vision testing carried out? School Nurses

- (b) By whom is colour vision testing carried out? Ishihara screening by School Nurses; "failures" tested in detail (Giles Archer Lantern) by Deputy Principal School Medical Officer.

- 5 (a) Is routine audiometric testing of entrants carried out within their first year at school?

YES	NO
✓	

- (b) If not, at what age is the first routine audiometric test carried out?

--

- (c) By whom is audiometric testing carried out? Audiometricians.

OBESITY

(Report by Dr. G. P. McLauchlan)

Concern has been felt for some time about the number of overweight children in the city. In February, 1967 a special clinic was started by the School Health Department to help these children to lose weight.

Children are referred to the clinic by their school medical officer or family doctor and some cases attend at the direct request of the parent. In all cases the family doctor is informed.

The clinic is held twice a month and attendance is by appointment. About 15 children, including 3 new cases, are seen at each session. Experience has shown that at least 20 minutes must be allowed for each new case in order that a thorough medical examination can be carried out and the diet discussed fully with the parent and child. Children are always seen one month after their initial visit and thereafter as considered necessary, but in most cases at two-month intervals.

Staffing. I am assisted at the clinic by a nurse (S.R.N.) who takes part of the history, tests the urine, arranges for the children to get undressed and weighs them. As the number of children attending the clinic has built up, it has been found necessary for a clerk to attend to free the nurse from strictly clerical duties and the making of appointments.

Treatment. Dietary treatment is started at the first visit; usually the child is put on a 1,000 calorie diet low in carbohydrate (in a few cases a 800 calorie diet has been found necessary). During the first visit some time is spent in explaining the diet to ensure that it is fully understood by both the parent and child. If the child stays to school dinners arrangements are made with the co-operation of the school meals staff and the head teacher for the diet to be continued at this meal.

A few children find it impossible to stick to the diet and need further help. They are put on a non-amphetamine appetite suppressant (Duromine) and the family doctors are informed.

Number attending

By the end of the year 54 children had been seen at the clinic.

8 of them had not yet been seen for their second visit, so there is no progress to record.

7 children stopped attending after a few visits, having failed to keep to the diet, and must be classed as failures.

2 children left the city shortly after starting the diet.

1 child at a residential school in the city lost weight while at school but regained it on returning home for the holidays.

The remaining 36 children (9 boys; 27 girls) have attended for periods ranging from one to nine months. There is no

recognised scale of weight and height but I have used that of Mitchell, Nelson Text Book of Paediatrics, 7th Edition, page 50 :

<i>Ages</i>		<i>Size of Family</i>		<i>Social Class</i>	
TABLE 1		TABLE 2		TABLE 3	
6- 9 years	4	Only child	8	Class 1	1
10-12 "	13	Two children	15	" 2	4
13-15 "	19	Three "	9	" 3	27
		Four "	2	" 5	2
		More than 5 children	2	Not classified	2

<i>Obesity in the Family</i>		<i>Percentage overweight at 1st Attendance</i>	
TABLE 4		TABLE 5	
As stated by mother and by observation of parent present		15% to 30%	9
No other member overweight	11	31% to 50%	13
One or both parents overweight	24	51% to 70%	8
Parents average but sibling overweight	1	71% to 90%	6

Birth Weight

There was nothing significant here—it varied from 5 lb. 10 oz. to 10 lb., with the majority between 7 and 7½ lbs.

Weight at one year old

Unfortunately, this was only available for 11 of the children. 9 of them were about their expected weight (three times their birth weight), the remaining 2 being 6 lbs. over. Both these children were at 5 years old within the average weight range.

Weight at 5 years old

7 of the children were found to be between 30% and 60% overweight at this age, the rest being around the average weight for their height.

Blood Pressure

In all but 6 of the children blood pressure was within the range 100/120 mm. systolic and 60/70 mm. diastolic.

2 children were found to have a systolic pressure between 130 and 150 mm. with normal diastolic pressure. 4 children had systolic pressure between 130/150 mm. with diastolic pressure between 75/90. Two months later after loss of weight the blood pressures of these 6 children fell within the normal range for their age.

Urine. This was tested in all children for sugar and albumin and in all cases the results were negative.

Results. Loss of Weight

It is only in those children who have been discharged from the clinic that one is able to give a complete picture of the results of treatment. The rate of weight loss varies from child to child and in individual children. During the course of treatment loss is usually greatest during the first few months on diet and then gradually slows down. In some cases there may be set-backs in which some of the weight lost is regained.

One must consider how much the child was overweight when he first attended the clinic—the loss of less than a stone may be a satisfactory loss in those only moderately overweight, while the loss of two stone by a grossly overweight child may still leave him much overweight.

It must also be remembered that the children attending the clinic are growing in some cases quite rapidly and with this growth in height there will be natural increase in weight. Some of the children have grown as much as 2 inches while attending and their natural gain in weight should be allowed for in assessing their weight loss.

Total Weight Loss

TABLE 6

6- 7 lbs.	6	No loss	2
8-14 lbs.	17	Slight weight gain	2
15-28 lbs.	7	Moderate gain	1
56-70 lbs.	1		

Average Weight Loss per month

TABLE 7

1- 5 lbs.	22
6-10 lbs.	6
10-15 lbs.	3
No loss	5

TABLE 8

WEIGHT LOSS ACCORDING TO PERIOD ATTENDING CLINIC

(as at end of 1967)

	0-7 lb.	8-14 lb.	15-28 lb.	56-70 lb.	No Loss
One Month	—	3	—	—	1
Two Months	—	2	—	—	—
Three „	1	3	1	—	1
Four „	—	2	1	—	1
Five „	—	2	3	—	—
Six „	2	3	—	—	—
Seven „	2	—	—	1	—
Eight „	—	—	1	—	2
Nine „	1	2	1	—	—

Measurements

At each visit measurements of chest (at nipple level), waist and hips (at greatest diameter) has been recorded and these have been found to give a good indication of loss of weight, especially when the child has grown. Both boys and girls take a great interest in these and the loss of an inch round the waist means more to them than the loss of several pounds.

TABLE 9

<i>Loss in inches</i>	<i>Chest</i>	<i>Waist</i>	<i>Hip</i>
1 in.—2.9 in.	20	18	17
3 in.—4.9 in.	6	10	7
5 in.—6.9 in.	2	3	2
7 in.—8.9 in.	1	—	1
No loss	7	5	9

(Harinden Skinfold calipers were used for measuring).

TABLE 10

Showing growth, weight loss, and measurements of those children with a substantial weight loss (figures in brackets are estimated weight loss, allowing for growth)

Sex	Age	First Attendance		Period in months	Latest Attendance		Wt. Lost (in pounds)	Chest		Waist		Hips	
		Ht. (in ins.)	Wt. (in pounds)		Ht. (in ins.)	Wt. (in pounds)		First (in ins.)	Latest (in ins.)	First (in ins.)	Latest (in ins.)	First (in ins.)	Latest (in ins.)
G	14	63.75	136	4	64	113	23 (23)	39	32.5	36	34.5	37.5	33.5
G	14	68	215	5	68	194	21 (21)	40	40	42	37	44	44
G	14	66	199	7	66	142	57 (57)	44.5	36	38	31.5	46.5	39
G	16	61.75	195	3	62	173	22 (22)	44	41.5	36	33.5	47	44.5
G	15	65	190	5	65.6	172	18 (22)	42	40	38	34	44.5	41
G	11	61.5	160	8	62.5	136	24 (28)	40	36	35.5	31	42	39
B	14	63	188	8	64.25	164	24 (30)	40	37.5	40	35.5	45	40
G	14	64	198	9	64	170	28 (28)	42	40	35	32	48	43
B	11	62.5	143	5	63	130	13 (18)	37	34	36	32	38	36
B	10	58	117	6	59.5	113	4 (14)	34	28	31	30	38	36
G	11	57.5	106	6	59	97	9 (15)	32	32	30	26	34	32.5
B	13	61.75	151	6	62.5	138	13 (20)	38	35.5	35	32	39	36.5
B	15	64	157	7	65.5	150	7 (15)	37	35	36.5	34	42	38
G	12	58	135	9	59.75	128	7 (14)	38	36	33	32	41	38
G	14	64	175	9	65	162	13 (21)	38	35	34	32	44.5	38

These show that because of growth the measured weight lost may be relatively small but that the reduction in chest, waist and hip measurement show a good loss of fat.

Discharge from Clinic

It is often difficult to decide when a child should be discharged from the clinic. I think that one cannot generalise on this and a decision must be made for each individual child. My impression from the small number I have so far dealt with is that many of these children are what is popularly called "large-boned" and their natural weight tends to be above average. So far 5 children have been discharged from the clinic, one (case 3, table 11 below) because she was leaving school and was not able to attend further, but was going to continue on diet. The other 4 cases were taken off diet but were given advice about restricting the intake of carbohydrate to some extent. Arrangements were made to see them all 6 months after stopping the diet. By the end of the year one girl (case 2) had been seen and in the six months since stopping the diet she had only gained 2 lbs.

Children Discharged from Clinic

TABLE 11

Case No.	Age and Sex	Start		On discharge		Wt. Loss	Period in months	Chest		Loss in ins.	Waist		Loss in ins.	Hips		Loss in ins.
		Ht.	Wt.	Ht.	Wt.			Start	Disch.		Start	Disch.		Start	Disch.	
1	G 15	ins.	lbs.	ins.	lbs.	lbs.		ins.	ins.		ins.	ins.		ins.	ins.	
		66	199	66	142	57	7	44.5	36	8.5	38	31.5	6.5	41.5	38	3.5
2	G 14	63.75	136	64	113	23	4	39	32.5	6.5	30	26.5	3.5	37.5	33.5	4.0
3	G 16	61.75	195	62	173	22	3	44	41.5	2.5	36	33.5	2.5	47	44.5	2.5
4	B 10	58	117	59.5	113	4	6	34	28	6	31	30	1	36	34.5	1.5
5	B 14	68	162	68	154	8	4	38	35.5	2.5	36	32	4	40	40	—

COMMENTS

In this report I have confined myself to giving factual information. My experience of the clinic has been too short and the number of children treated too small to allow for reliable interpretations.

However, a few comments can be made. First, has the clinic been a success? I think that even if it has only helped a few children to lose weight it is worthwhile. One must be prepared for failures—keeping on diet is difficult, especially after the first burst of enthusiasm has worn off. If a child is going to succeed in losing weight, it is essential that the parent should be interested and willing to help, and that the child himself should want to lose weight. The atmosphere of the clinic is kept on a friendly informal basis and as non-clinical as possible. No child is rebuked for not sticking to the diet, but encouragement is given to try harder. That obesity can affect their health in the future means little to children, but the greatest incentive especially to girls is that if they lose weight they can get clothes of their choice to fit them—the variety of clothes available for overweight children is very restricted.

Secondly, the cause of the children being overweight. In no child was any evidence of glandular deficiency found. Over-eating or eating a badly balanced diet with excess carbohydrate was found in all cases. Often it has been found that hearty eating was the family pattern. This over eating in most cases seemed to be a habit. In some cases at first it appeared that the child did not eat much; in fact sometimes the mother would say the child hardly ate anything, but when one went into the diet in greater detail one usually found that the diet was badly balanced and that though at meals the child did not seem to eat much, frequent “in between” snacks of biscuits, crisps, sweets and so on were eaten.

APPENDIX II

EXETER CITY COUNCIL

**Co-ordination of Education, Health and Welfare Services for
Handicapped Children and Young Persons**

Review of Services in accordance with Joint Circular 9/66 and 7/66 from the Department of Education & Science and the Ministry of Health.

EXISTING ARRANGEMENTS

EDUCATION SERVICE

An outline of the Education service carried out by the Youth Employment Service is as follows :

1. The Youth Employment Service is responsible for :
 - (a) Vocational Guidance and placing of all handicapped children and young people.
 - (b) The administration of the Disabled Persons Act for young people under 18 which includes initial registration as a disabled person.
 - (c) Liaison with and submission to :
 - (i) Ministry of Labour assessment schemes at Industrial Re-habilitation Units and Government Training Scheme at Government Training Centres.
 - (ii) Specialist handicapped agencies such as National Spastics Soc., Epileptic Association, etc., offering assessment, training, open and sheltered employment.
 - (iii) Junior sections of Local Authority Training Centres, under the Welfare and Mental Health Committees.
 - (d) Liaison with Factory Director where appropriate.
 - (e) Liaison with Appointed Factory Doctor where appropriate.

The service is responsible, not only for handicapped children and young people normally resident and completing their education in the City of Exeter but also for similar young people attending residential special schools who are normally domiciled elsewhere.

For young people from Exeter City attending residential schools outside the city but who expect to take up employment on

their return home, contact is maintained through the Youth Employment Officer in the area in which the school is located.

2. Sources of notification of handicapped young people to the Youth Employment Service :

- (a) Normal Secondary Schools leaving procedure for Vocational Guidance.
- (b) Special Schools (local)—normal school leaving Vocational Guidance procedures.
- (c) Special schools outside the area—initially through School Health Department, then through local Youth Employment Office in school's area.
- (d) Home-tuition cases—School Medical Department.
- (e) Hospital Referrals—School Medical Department for school leavers, Medical Social Work Department for older young people up to the age of 18.

3. **Procedure :**

- (1) Assessment in relation to employment prospects :
 - (a) Special steps are taken to identify handicapped young people in the final term of their penultimate year of statutory attendance at school.
 - (b) Relevant medical information from family doctors, hospitals, consultants, etc., obtained through School Health Service.
 - (c) Relevant social and family background obtained by :
 - (i) Teachers' reports.
 - (ii) Appropriate social worker concerned, e.g. Children's Officer, etc.
 - (iii) Interviewing of parents or guardians which could include home visit where appropriate.
- (2) *Guidance and Placing :*
 - (a) Contact established with organisations and associations dealing with various handicaps to enlist any specialist services of assessment, training and employment.
 - (b) Contact for assessment under M.O.L. Industrial Rehabilitation Units if required.
 - (c) Contact with Welfare or Mental Health Training Centres where appropriate.

These centres are often used in a temporary way to act as a transition between full-time education and employment for those who are proving very difficult to place or who may need time to mature before entering open employment.

(3) *Timing :*

Progressively, because of the time taken to complete some of the procedures under para. 2, the timing of these contacts has moved back. A start is usually attempted to identify cases in the last term of the penultimate year of school.

This ensures that the longer procedures can be completed before leaving.

HEALTH SERVICE

The services in Exeter for handicapped persons seem to be working well, and as far as children are concerned, at least, it is fair to say—though it is not a small claim—all are known to the Health Department. Co-operation with the Education and Welfare Departments of the Council is good, as is co-operation with the hospitals and voluntary organisations.

1. Ascertainment of Handicapped Children

Children with handicaps likely to affect their education, or ability to earn a livelihood, or who are likely to need help from the health or welfare services of the Council, are ascertained in various ways.

(1) Those with congenital abnormalities normally become known shortly after birth from midwives' reports, though some, when the congenital abnormality is not manifest at birth, are ascertained by the other methods described below.

(2) An "at risk" register is kept of all babies who, as the result of some ante-natal, peri-natal or post-natal conditions in mother or child, are "at risk" of developing some handicap later. These children are carefully watched to detect any such handicap early. A special mention should be made of deafness; special examinations for hearing are made during the first year of all children on the register who may be considered as at risk for hearing loss.

(3) Health visitors and clinic doctors may in the course of their work, including home visits, discover conditions in children likely to cause handicaps. Family doctors are another valuable source of information. Such conditions are recorded and observation maintained.

(4) The School Medical Officers, during their medical examinations and visits to schools, ascertain handicapped children whose handicap has developed later, either as a late developing congenital lesion, or one developing as the result of illness or accident.

(5) Reports are received from the hospital of all children attending there, and in some cases the first indication of a handicapping, or potentially handicapping condition, may be gained from these reports.

2. **Special Schooling**

When a pre-school child is found with a handicap that may require special educational facilities, consideration is necessary as to the need, the right placing and the right time for any special placing. A record is maintained and the case is ordinarily reviewed during the year before the child is due to start school, to decide whether he should go to ordinary school or whether he will need special schooling. In certain conditions, viz. severe hearing loss, severe mental subnormality or blindness, it is usually desirable that the child should be sent to a special nursery school (or training centre in the case of the severely mentally subnormal) at an early age ; when this is considered necessary it is arranged.

Considerable attention has been given by the Council to the early ascertainment and treatment of deaf and partially hearing young children, and a well-equipped audiology clinic has been established for hearing assessment purposes : a team including hospital consultants and teachers of the deaf and members of the Health Department staff attending.

During the child's school life any handicap found is noted and the handicap assessed as to educational needs.

Head teachers are kept informed of any children in their schools with a handicap likely to affect his life in school.

When it is considered that it would be to the benefit of a handicapped pre-school child, admission to the day nursery may be arranged.

3. **Children at Special Schools**

Children attending special schools, either as day pupils or at residential schools, are kept under constant review and are seen and assessed by one of the school medical officers at least once a year.

4. **On Leaving School**

During the child's last year at school every handicapped child is seen by the School Medical Officer and the child's case reviewed and assessed as to his suitability for employment, and any restrictions that may be advised on the type of employment(s) he can undertake. The future of the child is discussed with the parents ; the Youth Employment Officer is informed of the child's handicap and any restrictions considered necessary. When considered necessary the case is discussed personally with the Youth Employment Officer.

Occasionally an educationally subnormal school-leaver may be found to be unsuitable for employment, and the parents are then seen by the Mental Welfare Officer with a view to training at the Mental Health Centre (Nichols Centre). Also when it is considered necessary, in the case of an educationally subnormal child, and with the parents' agreement, the Mental Welfare Officers may be asked to give help and supervision (care and guidance) after he leaves school.

Severely mentally subnormal children are made the care of the Mental Health Section while attending the Junior Training Centre (Ellen Tinkham House School), and will normally go to Nichols Centre when leaving there. These children often suffer from physical handicap ; some are spastics as well as mentally handicapped. A medical officer visits the Ellen Tinkham House School frequently, and all children there are kept under constant review.

Where it is considered necessary, children with physical handicaps are referred to the Welfare Officer when they leave school, for his help.

5. Case Conferences

Case Conferences of those concerned are not held regularly, but occasionally when it is considered that it would be to the benefit of the child they are arranged.

6. Health Visitor for Handicapped Children

A health visitor has been allocated special duties in the care of handicapped children, other than of severely mentally subnormal children which is the responsibility of a Mental Welfare Officer.

7. Handicapped Adults

Except for those handicapped because of mental subnormality, or mental illness, the department ordinarily does not have direct contact with handicapped adults, except

- (a) in a virtually nominal way in relation to the blind, and
- (b) in that through health visitor contacts and housing enquiries a number of handicapped persons are discovered and these are referred to the Welfare Department.

In relation to those mentally disordered the Council have taken very active steps in regard to their training. When information of a handicapped adult needing help, or likely to require it, is received from a health visitor, home nurse or family doctor, this information is passed to the Chief Welfare Officer.

WELFARE SERVICE

1. Registration under National Assistance Acts, 1948/62

The Welfare Department is required to maintain classified registers of handicapped persons under the provisions of Section 29 of the National Assistance Act, 1948. The registers are divided into three categories :

- (1) Blind and Partially Sighted.
- (2) Deaf and Hard of Hearing.
- (3) Other handicapped Persons (General Classes).

N.B. Under Category (3) a handicapped person means one who is substantially and permanently handicapped by illness, injury, or congenital deformity or such other disability as may be prescribed by regulations.

Registration of persons under (1) and (2) is conditional on the receipt of the relevant medical reports. Under (3) registration may be conditional on the need to provide an appropriate service under the provisions of the Act, although this requirement is at the discretion of the local Welfare Authority.

At present the registers include the following categories of handicapped children who have been notified to the Department by the School Medical Officer of Health :

<i>Categories</i>	<i>Age Group</i>	<i>Number</i>	<i>Total</i>
Blind and Partially Sighted	0— 5	—	—
	5—16	5	5
Deaf	0— 5	1	—
	5—16	54	55
Other handicapped	0—16	2	2
			—
			62
			—

2. Registration of children up to the age of 16 years

Registration of handicapped children is effective on the receipt of formal notification from the School Medical Officer of Health, with whom close contact is made. These registrations cover mainly blind and partially sighted children and deaf and hard of hearing children—only exceptionally is the Department notified of a child who is substantially and permanently handicapped—e.g. where there is reason to believe that the child will continue to require permanent residential care on attaining the age of 16 years in an establishment recognised for the purpose under Section 21 of the National Assistance Act, 1948, in which event, the responsibility for maintenance will then be assumed by the Welfare Authority.

3. Provision of Welfare Services to children under the age of 16 years

For children registered under categories (1) and (2) the Department may be required to provide specialist services through the medium of officers qualified for the purpose—i.e. Home Teacher for the Blind and Welfare Officer for the Deaf. These officers maintain contact with the children and the family throughout school life and work closely with the appropriate officers in the Health and Education Departments on matters affecting the child's social well being.

4. Provision of Welfare Services to children on attaining the age of 16 years

For children in categories (1) and (2) in particular, and for any child who is substantially and permanently handicapped, consultation takes place with the Youth Employment Officer with a view to ensuring that the necessary supporting services under the provisions of Section 29 of the Act are made available to any child deemed to require same on attaining the age of 16 years.

Appropriate services include, in particular, therapy instruction, diversionary occupations and social and industrial rehabilitation. For children deemed likely to require permanent residential care in an establishment appropriate to the provisions of Section 21 of the National Assistance Act, 1948, the Department co-operates closely with the appropriate officers of the Health Department.

PROPOSALS FOR IMPROVING THE EXISTING ARRANGEMENTS

- (1) The various authorities concerned will foster the development of assessment clinics for infants and pre-school children as envisaged in the Sheldon Report, either in hospital or local authority premises.
- (2) The local authority will keep the arrangements indicated in paragraph 6, *supra*, of this statement (health visitor for handicapped children) under review and will appoint further staff as may be necessary.
- (3) The school health service will encourage so far as practicable the non-maintained schools to bring to the notice of the department children who are handicapped.
- (4) In order to make more comprehensive the information available about handicapped children when approaching school leaving age, the school health department will consult family doctors and hospital consultants, in relation both to the current medical condition of the children and to their doctors' views about employment possibilities.
- (5) The school health department will send to the youth employment officer details of each handicapped child rather more than a year before the child leaves school. Shortly afterwards, the principal school medical officer will convene a meeting of representatives of the school health service, the youth employment service, the city welfare service, the mental health service and others as may be appropriate, to discuss these children as well as any others referred from other sources. Where appropriate, as for example, in the orthopaedic field, the medical social worker will be brought into discussions. So far as practicable, the family doctors and/or consultants will be notified of the conclusions reached. By these various means, the youth employment officer will have the opportunity during the child's last year at school of considering the employment prospects and also possible efforts in vocational guidance.

(Note : The Education Authority has offered all the services of the School Health Department to the non-maintained schools at a nominal charge—one school has adopted this arrangement—and makes available to handicapped children in these schools without charge certain school health therapeutic services.)

- (6) The Authority will consider appointing one of the youth employment staff as a part-time specialist in relation to the employment of handicapped young persons and this officer will be given the opportunity to attend the Executive Specialist Training Course of the Handicapped.

FURTHER SUGGESTIONS FOR IMPROVING THE SERVICES

1. It is recommended that the Department of Education and Science should consider making the Local Education Authority of the area in which any special school recognised or approved by the Department, not maintained by the Authority, is situated, responsible for providing the same range of service in such a school as is provided in the Authority's schools.
2. The training of staff of junior training centres for mentally subnormal children, should, it is considered, be undertaken by the Department of Education and Science. It is also considered that junior training centres should be named as schools, but no opinion is expressed as to whether they should be conducted by the Education or the Health Authority.

